

Primary school teachers' views on their role in child mental health prevention.

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ABSTRACT

Background: With evidence of rising mental health needs in children and young people and cuts in specialist provision, the role of schools in the prevention of child mental health issues has become increasingly pertinent. Primary school teachers work with an age group for whom early intervention is of particular relevance and are being asked to perform a range of educational and preventative tasks relevant to the mental health of their pupils.

Objectives: This study aimed to explore primary school teachers' perspectives on their role in the prevention of child mental health issues and gain a better understanding of opportunities and barriers they may encounter in this role.

Design: This was an exploratory study using thematic analysis. A critical realist position was taken which allowed both the content of the data and the context of the teacher's views and experiences to be considered.

Method: Semi-structured interviews were carried out with 11 teachers working across 10 primary schools. Data was analysed using thematic analysis, following the stages of analysis outlined by Braun and Clarke (2013).

Results: Two overarching themes were identified: i) Understandings of child mental health and ii) School's place in society; teacher roles and responsibilities.

Conclusions: The findings demonstrate the complex position primary school teachers hold, in which they face dilemmas around the boundaries of their role and contend with the restrictions and demands of the current UK education system. The findings indicate a lack of confidence in how best to identify and respond to children presenting with mental health issues and a desire for further training on the subject of mental health. The findings highlighted a need for greater clarity in the parameters of a primary school teacher's role and further consideration of the feasibility of incorporating mental health education and prevention into an already high workload.

1. INTRODUCTION

1.1 Overview of mental health in the UK

There has been a growing focus on mental health in the UK and an increased awareness of the prevalence of mental health issues. This prevalence is demonstrated in the often cited statistic that one in four people in the UK will experience a mental health problem in any given year (Mental Health Foundation, 2015). A survey of adult mental health in England has been carried out every seven years, with the most recent Adult Psychiatric Morbidity Survey taking place in 2014. The results of this survey indicate that 1 in 6 adults have experienced a common mental health issue, such as depression or anxiety, in the past week and these issues have become more widespread since 1993, increasing in prevalence by around one-fifth (Baker, 2020). Levels of distress are reflected in the rate of UK suicides. In 2018, with 11.2 recorded suicides per 100, 000 people, the rate had an 11.8% increase from 2017 and was at its highest level since 2002 (Office for National Statistics, 2019). Suicide appears to be an issue that disproportionately affects males, with men accounting for three quarters of the number of people who ended their own lives in 2018 (Office for National Statistics, 2019).

In addition to the personal, relational and societal effects of poor adult mental health, the wider economic costs are vast, estimated at £105 billion each year in England (England.nhs.uk, 2016). It has been found that almost 1.8 million work sickness notes were provided by UK GPs between September 2016 and September 2018 for mental health reasons, accounting for a third of all sickness notes (NHS Digital, 2019). In spite of this broad reaching impact, funding for mental health services is still too low and lacks parity of esteem with physical health services (The King's Fund, 2018).

Definitions and conceptualisations of mental health and mental health problems have been widely debated (Horwitz and Wakefield 2007; Malla et al., 2015; Manwell et al., 2015; Telles-Correia, 2018) and there are concerns that typical, human reactions of sadness, anger and grief are medicalised in Western models of mental health (Scott, 2010; Sanders, 2006). Although the social and institutional functions served by the medical model and psychiatric diagnosis have been questioned

(Moncrieff, 2010; Harper, 2013) and alternative frameworks of understanding are gaining traction (Johnstone and Boyle, 2018), an individualised, medical model continues to dominate mental health provision and public discourse around mental health in the UK (Beresford et al., 2016). This focus can neglect to acknowledge or pay sufficient attention to the social causes of mental distress, including poverty and social inequalities (Lemstra et al., 2008; Reiss, 2013)

The term mental health will be used in this thesis in line with the World Health Organisation's definition of "a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2014).

1.2 Child and adolescent mental health

1.2.1 Prevalence of child and adolescent mental health issues in the UK

In a survey of 1008 GPs across the UK, 90% agreed that they had seen a rise in the number of young people seeking mental health support in the last three years (Young Minds, 2019a). Whilst a deterioration in the mental health of children and young people has been widely discussed over the past decade (Collishaw, 2015; Gunnell et al., 2018) there is some uncertainty about the nature of the apparent increase in prevalence, with speculation that it may reflect improved awareness and identification. Pitchforth et al. (2018) found that despite a striking increase in the self-reported prevalence of long-standing mental health conditions among children and young people in recent years, this was not always reflected in reported psychological distress when measured using scores in validated questionnaires. They suggested that parents and young people are now more likely to report that they are concerned about mental health problems (Pitchforth et al., 2018).

There have been widespread reports of an increase in psychiatric distress in this population, demonstrated in part by increasing rates of self-harm (Mental Health Foundation, 2006; Borshmann and Kinner, 2019) particularly amongst adolescent girls (Morgan et al., 2017). Suicide rates in England and Wales increased by 7.9% each year per 100,000 adolescents aged 15 –19 years between 2010 and 2017 (Bould et al., 2019). In 2018, the Office for National Statistics showed a 13.9% rise

in the suicide rate among 10 to 19 year olds since 2017 with the highest rate in 19 years for 10 to 24 year olds. Suicide is the most common cause of death for boys aged between 5 and 19 in the UK, and the second most common for girls of that age (Office for National Statistics, 2018)

The findings of the NHS 2017 Mental Health in Children and Young People survey indicate that one-in-eight five to nineteen year olds in the UK meet the diagnostic criteria for at least one mental health condition. While the survey has shown only a modest increase in diagnosable mental health conditions, from 10.1% in 2004 to 11.2% in 2017, the overall figure includes concerning rates of mental distress (NHS Digital, 2019). Emotional mental health conditions, including anxiety and depression, have increased in prevalence among 5 to 15 year olds from 3.9% in 2004 to 5.8% in 2017. Other types of conditions, such as behavioural, were shown to have remained of similar prevalence in this age group since 1999. Of the children and adolescents in this survey, 66.4% of those with a diagnosable mental health condition had contact with a professional in the past year in relation to their mental health concerns. The importance of the role of educational professionals was made evident, with teachers cited as the most common source of support (48.5%).

Aside from what are considered to be diagnosable mental health conditions, young people in the UK have been found to be unhappier overall than their peers elsewhere. A 2018 OECD survey found that adolescents in the UK are more likely to be miserable and less likely to think that their lives have meaning compared to children in other countries. The British 15 year old participants' responses were ranked 69th out of 72 countries for life satisfaction and under half of these British adolescents reported satisfaction with their lives. In a 2019 survey, The Children's Society found that almost a quarter of a million children in the UK reported themselves to be unhappy with their lives as a whole, with UK child happiness at its lowest recorded level since 2009.

1.2.2 Issues faced by children and young people

The levels of unhappiness and diagnosable mental health conditions in children raise the question of what is happening in the UK that is causing our children to feel this way.

Education policy, particularly following changes made under the Coalition Government between 2010 and 2015, has resulted in increased pressure on academic outcomes with a greater focus on league tables and exams. Numerous studies have listed school related stress as a significant cause of anxiety for children and young people (Cowburn and Blow, 2017; The Children's Society, 2019). Research has indicated that the focus on academic attainment within the education system is having a negative impact on children, with 80% of young people reporting that exam pressure has significantly impacted on their mental health (Cowburn and Blow, 2017). Teachers have supported this finding, with 82% believing the focus on exams in schools has become disproportionate to the overall wellbeing of students (Cowburn and Blow, 2017). Hutchings (2015) found that increased testing pressure, a greater awareness at younger ages of their own 'failure' and the increased rigour and academic demands of the curriculum have had negative impacts on children's mental health.

Social media is used increasingly by children and adolescents and appears to be another contributory factor to poor levels of mental health, although this may not be an issue exclusive to the UK. The Office for National Statistics 2015 national wellbeing survey identified a clear association between longer time spent on social media and mental health issues. Research studies have linked social media with increased anxiety and depressive symptoms, negative body image, sleep problems, self-harm, suicidal ideation and cyberbullying (Royal Society for Public Health, 2017)

Children in the UK also appear to be worried about their futures and broader societal and environmental issues. In a 2020 Newsround survey asking 2000 eight to 16 year olds about their futures, almost three in five, or 58%, said they were worried about the impact that climate change will have on their lives, with 17% stating that their sleeping and eating habits were affected by their concerns. According to 2019 research by Action for Children, children and adolescents aged 11 to 18 are also worrying about issues such as Brexit, homelessness, inequality and terrorism.

1.2.3 Prevention of child mental health issues

Preventative interventions in mental health aim to reduce the incidence, prevalence and recurrence of mental health issues. Increasing evidence supports the efficacy of universal and selective preventative interventions to promote mental wellbeing and prevent mental health issues throughout development (Arango et al., 2018).

Preventative programmes can involve a combination of strategies for reducing exposure to risk factors and enhancing protective factors. Arango et al. (2018) summarised the following levels at which mental health prevention can be delivered. Mental health promotion, delivered across whole populations, promotes psychological wellbeing and the achievement of developmental milestones. Schools may deliver this level of intervention in the form of mental health literacy programmes and programmes focused on the development of resilience and coping skills. Universal primary prevention involves approaches which target risk factors in the whole population to prevent the development of mental health problems, for example a reduction of income inequality and unemployment in the general population and anti-bullying interventions in schools. Selective primary preventative interventions focus on individuals or subpopulations with a higher than average risk of developing mental health difficulties, targeting risk factors and strengthening abilities in individuals. Indicated primary preventative interventions focus on individuals at high risk who present with early indications of mental health issues, without currently meeting diagnostic criteria. Lastly, secondary preventative interventions are aimed at individuals who meet psychiatric diagnostic criteria and would benefit from early identification and intervention.

The Mental Health Foundation's 2020 report on tackling inequalities to reduce mental health problems states that concurrent action is required at structural, community, group and individual levels in order to reduce the prevalence of mental health problems. Structural measures consist of actions to change the social and economic influences that can lead to mental health problems, including a reduction in income inequality, poverty, domestic violence, discrimination and homelessness. Community level interventions include activities to increase social connections, improve community environments and foster participation in community decision-

making. Measures at the individual level can involve education about how to look after one's mental health, resilience training and empowerment programmes.

A whole-school approach to mental health can attempt to address multiple levels of prevention with a combination of community, whole-school population and targeted small group and individual activity. NICE advise that all primary and secondary schools should adopt a comprehensive whole school approach to promote the social and emotional wellbeing of children and young people (Mental Health Foundation, 2016). Whole-school approaches to mental health prevention involve the development of a school culture and ethos which support the wellbeing of the entire school community and promote good mental health (Mentally Healthy Schools, 2020). This includes addressing the curriculum, providing early support for pupils and focusing on positive, protective relationships with pupils and families. Interventions are aimed at strengthening broader protective factors which promote children's resilience and reduce risk factors in families, at school and in the local community (Mentally Healthy Schools, 2020).

Public Health England (2019) carried out a synthesis of systematic reviews of 113 universal approaches to improving the mental health and wellbeing of children and young people. Although the whole-school approach highlights the importance of working with the systems around childhood, the review found that many more interventions operate at an individual level, rather than at a school or family level, and no interventions were identified that operated at a community level. The outcomes most commonly reported were preventing emotional difficulties, improving resilience and preventing behavioural difficulties.

1.3 CAMHS under pressure

Of the 1008 GPs in the 2019 Young Minds survey, 76% said they did not feel confident that young people they referred to CAMHS would receive treatment. The rising demand for care, increase in complexity of needs, workforce issues and constraints on budgets have all been identified as significant factors in the challenge of delivering effective care in child and adolescent mental health services (Care Quality Commission, 2018). The loss of many preventative and early intervention services, generally provided by local authorities, in addition to rising thresholds in

community CAMHS, has led to increasing numbers of children and young people reaching crisis point (Care Quality Commission, 2018). There is wide geographical variation in the extent to which local CAMHS are accessible and adequately resourced (Rocks et al., 2019).

The children's mental health charity Young Minds found, via a Freedom of Information request in 2015, a minimum of £85 million in cuts to mental health budgets for children and young people since 2010 across mental health trusts, clinical commissioning groups (CCGs) and local authorities. In 2015, the UK government committed an extra £1.4 billion to CAMHS over the following five years. A further Young Minds analysis suggested that, in 2017-18, 43% of CCGs had actually increased their CAMHS budgets by less than the extra money they had been allocated, sometimes spending the money on priorities other than child mental health. While the majority of CCGs had increased their CAMHS budgets, over half of local authorities had actually cut their CAMHS budgets in real terms since 2013 - 2014, with CCGs funding services previously funded by local authorities. In some areas, CCGs had increased their CAMHS budgets by more than the additional investment, which indicates the inconsistency of approach across the country.

Amidst ongoing funding challenges, the number of children and young people referred to CAMHS in England increased by 18% from 343,386 in 2017 – 2018 to 405,479 in 2018 – 2019 (NHS Digital, 2019). Since 2010, the number of admissions to A&E of children and young people diagnosed with psychiatric conditions has increased by a striking 330% (NHS Digital 2019). However, greater awareness and recording of psychiatric conditions by staff in A&E departments may account for some of this increase (NHS Digital, 2019).

A 2019 report by The Children's Society estimated that more than 185,000 children and young people aged 10 to 17 were referred to specialist mental health services in 2017, but only 79,000 received treatment that year. This indicates that around 60% of those referred were not treated in the same year. The Children's Society suggested that due to high treatment thresholds, young people's needs may not be addressed promptly and they are therefore more likely to reach the point of crisis. These concerns were echoed in a 2019 survey carried out by the National

Association of Head Teachers with 653 school leaders (2020). Only 4% of the participants agreed that CAMHS respond promptly to requests for support and only 5% believed children referred to CAMHS “get help when they need it”.

Research by the Education Policy Institute (Crenna-Jennings and Hutchinson, 2020) estimated that one in four of those referred to child mental health services in England in 2018 – 2019 were not accepted for treatment, including young people who have self-harmed, suffered eating disorders and experienced abuse. Despite government commitments to address shortages in CAMHS provision, referral rejection rates have remained unchanged over the last four years. The most common reasons provided for rejected referrals included the child or young person’s condition not being suitable for treatment or their condition not meeting service eligibility criteria (Crenna-Jennings and Hutchinson, 2020). NHS England, in response to the 2019 EPI report, stated that it was wrong to assume that every referral should result in NHS treatment when more appropriate support might be provided by other services, including schools (Weale, 2020).

Health secretary Jeremy Hunt has referred to children’s mental health services as “the biggest single area of weakness in NHS provision” (Gammie and Linton, 2016). He recommended furthering the integration of CAMHS in schools with the hope that children and young people’s mental health problems can be identified before they increase in complexity and intervention becomes more difficult.

1.4 Government mental health guidance and policy implications for schools

Children and young people’s mental health has become a national priority and the government has commissioned a number of recent policies and reviews to address children and young people’s mental health services at a national and local level.

NHS England’s Five Year Forward View (2014), placed greater emphasis on prevention and integration of services. The 2015 Future in Mind report outlined government aspirations for children and young people’s mental health to be reached by 2020. The recommendations included: improved public awareness and understanding; timely access to effective mental health support across the country;

training in child development and mental health for all professionals who work with children and a move away from a tiered model. In 2016, the Five Year Forward View for Mental Health in England outlined strategic planning to deliver mental health care across the lifespan and supported the recommendations made in Future in Mind (2015).

The government green paper 'Transforming children and young people's mental health provision' (2017) proposed changes for schools. These included a proposal that all school staff teams should have a designated mental health lead by 2025. The designated leads will be trained and responsible for overseeing the school's approach to mental health and the support received by pupils. They will help other staff to 'spot pupils who show signs of mental health problems', offer advice to staff about mental health and make onwards referrals to specialist services if necessary. A further proposal coming from the green paper is that Mental Health Support Teams will be connected to schools, offering individual and group support to pupils with mild to moderate mental health issues and providing a link with NHS specialist mental health services. The government aims to implement these new approaches in at least a fifth of the country by the end of 2023. The paper asserts that, 'appropriately trained and supported staff, such as teachers, school nurses, counsellors and teaching assistants, can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild-moderate mental health problems'.

In the Department for Education's (hereafter DfE) 2018 non-statutory advice document 'Mental Health and Behaviour in Schools', it emphasises the key role of teachers in promoting child mental health and wellbeing and the potential for schools to intervene early to "strengthen resilience before serious mental health problems occur". It recommends a whole school approach to mental health and wellbeing, which should incorporate a safe, calm and structured school environment with "clear expectations of behaviour, well communicated social norms and routines" and mental wellbeing taught through the curriculum. It specifies that school staff "cannot act as mental health experts and should not try to diagnose conditions." They should, however "have clear systems and processes in place for identifying possible mental health problems, including routes to escalate and clear referral and

accountability systems". When schools suspect a pupil has a mental health problem, they are advised to use "assess-plan-do-review". The DfE add that identification tools, such as the Strengths and Difficulties Questionnaire, can be used to support this process. An effective pastoral system is recommended, with each pupil being known well by at least one member of staff and all staff trained in how to "spot where bad or unusual behaviour may have a root cause that needs addressing". School's roles in early identification, intervention and referral to external agencies are highlighted as well as the expectation that they will develop approaches "tailored to the particular needs of their pupils".

The role of schools in the prevention and management of child mental health issues has been evident in further recent nationwide plans. The NHS long-term plan, published in January 2019, set out key priorities for expanding and improving children and young people's mental health services over the next ten years. The aims include widening access to services closer to home and the reduction of delays. By 2023-2024, 345,000 additional children and young people should have access to support via NHS funded mental health services and school based Mental Health Support Teams.

In June 2019, Theresa May announced a 'mental health prevention plan' which holds implications for professionals across the fields of education, health and social care. The prevention plan has the aim of ensuring "people have the confidence and skills they need to identify mental health issues before they become critical, particularly in young people" and intends to support professionals to "promote good mental health in the same way that they look after physical wellbeing" (Gov.uk, 2019). The planned measures include suicide prevention training for NHS staff and updated professional standards for social workers. In the education sector, there will be training for all new teachers on how to 'spot the signs' of mental health issues and this will be backed up by statutory guidance to clarify schools' responsibilities to 'protect children's mental wellbeing'. School mental health leads will be given support to 'help children struggling with self-harm and suicide risk' and teachers will have access to 'world-class teaching and training materials' for the provision of mental health education for all primary and secondary school pupils.

1.5 School based mental health prevention

1.5.1 Approaches to mental health prevention in schools

Increasingly stretched CAMHS provision and an emphasis on early intervention has shifted government focus from clinical to community settings, including schools (Stallard et al., 2012), which have been described by Professor Tamsin Ford as “our default front line service in relation to mental health” (2019). Resnick argued that schools should be involved in the “intentional, deliberative process of providing support, relationships, experience and opportunities that promote positive outcomes for young people.” (2005, p. 398)

In a 2019 poll by the National Association of Head Teachers, 66% of school leaders said they were commissioning their own professional support for pupils, including school-based counsellors. The survey found that 79% of schools adopt a whole-school approach to positive wellbeing and 78% have a designated staff member responsible for mental wellbeing. Only 44% of those surveyed thought that staff would feel confident in dealing with a pupil experiencing a mental health crisis and some pointed out that the lack of capacity in specialist services for those with more serious problems.

The concept of resilience is referred to often within the fields of both mental health and education and the implications of this concept are that all children, regardless of level of risk or current mental health status, can benefit from support in the development of effective strategies and skills. Linquanti (1992, p.2) defined childhood resilience as “that quality in children who, though exposed to significant stress and adversity in their lives, do not succumb to the school failure, substance abuse, mental health, and juvenile delinquency problems they are at greater risk of experiencing.” Rutter’s (2012) formulation of resilience recognises that resilience is a developmental process which can be nurtured within family and other social contexts. Schools may be well positioned to nurture this developmental process, given the exposure pupils have to a variety of school based experiences throughout their childhood.

Whole-school approaches have been shown to be most effective in promoting wellbeing and good mental health (Department of Education, 2016) and have been demonstrated to improve staff and pupil wellbeing and have a positive impact in the prevention and reduction of mental health problems in pupils (Weare, 2015). In *Future in Mind* (2015), the Government encouraged all schools to develop whole school approaches to mental health and wellbeing. However, there has been criticism that despite the development of several comprehensive frameworks for whole school approaches, the Government has not introduced specific funding streams, accountability measures, or processes to enable schools to put this into practice (Cowburn and Blow, 2017).

A survey of 599 primary and 137 secondary schools in England found that although two thirds of schools reported input for all pupils, interventions did not focus on prevention and were instead mainly aimed at children and young people with developing or established mental health problems (Vostanis et al., 2012). The survey indicated broadly similar approaches in primary and secondary schools, with a range of listening, communication and problem-solving skills appearing to be the first in-house response for the vast majority of children. The survey found that few schools considered training, consultation, supervision, counselling or support for teaching staff as a key part of their overall approach to supporting pupils' mental health. The study also indicates that successful implementation of programmes in a school context could require additional resources not normally available to schools.

1.5.2 Efficacy of school based interventions

As part of the European Union DataPrev Project, a systematic review of existing reviews of universal and targeted school based mental health programmes was conducted between 2007 and 2009. The review endorsed the importance of work to promote mental health and prevent mental health problems in schools and identified very few examples of adverse effects. The interventions identified were found to have a wide range of beneficial effects on children, families, communities and on a range of mental health, social, emotional and educational outcomes (Weare & Nind, 2011). Generally, the effect sizes associated with most interventions were found to be small to moderate in statistical terms but large in terms of real-

world impacts. The effects associated with school based interventions were variable and their efficacy could not always be relied upon. The characteristics of more effective interventions included teaching skills, focusing on positive mental health, balancing universal and targeted approaches, starting early with the youngest children and operating for a lengthy period of time (Weare & Nind, 2011). A further characteristic of more effective interventions was embedment within a whole school approach which included features such as changes to the curriculum, improving school ethos, teacher education, liaison with parents, parenting education, community involvement and coordinated work with outside agencies (Weare and Nind, 2011). School interventions were found to be effective only if they were completely and accurately implemented. This finding was particularly applicable to whole-school interventions, which could be ineffective if not implemented with clarity, intensity and fidelity (Weare and Nind, 2011).

A more recent systematic review found that the effectiveness of UK school-based universal interventions, that aim to promote emotional wellbeing or prevent mental health difficulties, is neutral to small (Mackenzie, 2018). The review did find, however, that studies based in primary schools seemed to have more encouraging results from CBT based interventions on measures of anxiety. The more positive results tended to occur among older primary school pupils, in the 9 -12 age range. Another study found that mental health promotion programs which focus on resilience and coping skills have been demonstrated to have positive impacts on primary school pupils' ability to manage daily stressors (Fenwick-Smith et al., 2018)

1.5.3 Critical perspectives on school based interventions

Watson (2012) commented on the almost uncritical acceptance of the apparent need to improve wellbeing among school aged children in the UK. She referred to wellbeing as a social construct that is contextual, fluid and ever evolving with a high degree of ambiguity. In addition to the concern that policy initiatives pathologise pupils as lacking in wellbeing, she critiqued the normalisation and operationalisation of wellbeing concepts in education settings through the use of targets, outcomes and measures. She pointed out the inherent contradiction in making teachers

responsible for pupil wellbeing while, simultaneously, the National Curriculum limits and controls teachers' input into their own specialist subjects.

The usefulness of the concept of resilience, frequently referred to in education settings, has been debated. Doll argued that resilience emerges out of the systemic interdependence of children with their families, communities and schools (2013). Some school based approaches, which promote individual protective factors, may neglect to acknowledge the systemic aspect of resilience. Ecclestone (2007) presented a critical view of the assumptions underlying many school based interventions, including the fundamental belief that emotional wellbeing and self-esteem are the basis of citizenship and social harmony. She described how emotional wellbeing policy initiatives in education resonate with images of the 'diminished self' which are evident in broader cultural discourses. Ecclestone suggested that, despite the rhetoric of empowerment and resilience, discourses of emotional wellbeing reveal a pessimistic tone that privileges narratives of damage and vulnerability. It has been argued that school based interventions, and the therapeutic ethos that underlie them, adhere to a deficit based model and may have the potential to legitimise beliefs about the fragile self rather than the empowered, autonomous and resilient self (Ecclestone, 2007; Watson, 2012).

Furthermore, discourses of emotion inherent in school based initiatives have been argued to be susceptible to exploitation by policymakers and practitioners. A study that explored the views of UK Primary school staff on social and emotional learning approaches found a propensity to conflate social and emotional aspects of self with more moralistic constructs of identity (Wood, 2018). The findings indicated that the school staff had a tendency to prioritise specific aspects of emotional intelligence, such as emotional control. Participants' responses suggested a propensity to attribute issues with these aspects of emotional intelligence to certain groups of children, with interventions serving to 'other' children from deprived and minority ethnic communities. Wood argued that such schemes have the potential to act as tools of cultural imperialism by problematising, marginalising or endorsing certain values, norms and behaviours.

Additionally, concern has been raised that school based interventions, such as *Every Child Matters*, may impact on children and young peoples' right to privacy to explore their feelings, experiences and worries away from the gaze of the state (Hoyle, 2008). Therefore, wellbeing initiatives could be viewed as having the potential to impede, rather than improve, the lived experience of children and potentially carry negative consequences for children's rights, identity formation, emotional development and wellbeing (Hoyle, 2008).

1.6 Issues in the teaching profession

1.6.1 Pressures on teachers

In Worth and Van den Brand's 2019 annual report on the English Teacher Labour Market, they suggest that although teachers' working hours averaged over the whole year are similar to those in many other professions, working intensively over fewer weeks of the year may lead to a poorer work-life balance and higher levels of stress. They found that 41% of teachers are dissatisfied with their amount of leisure time, compared to 32% of similar professionals. Compared to 13% of those in similar professions, 20% of teachers were reported to feel tense about their job most or all of the time. Worth and Van den Brand recommended a reduction in teachers' workload as an area with the biggest potential for improving retention. Indeed, workload has been found to be the most important factor in influencing teachers' decision to leave the profession (Department of Education, 2018). In the National Education Union's 2018 workload survey, which collated responses from 8,173 primary and secondary school teachers in England and Wales, 81% had considered leaving the profession due to the workload.

Accountability measures within UK schools have resulted in additional sources of pressure and an increased workload for teachers. Hutchings (2015) found that Ofsted, described by teachers in the research as 'random' and 'punitive', caused greatest concern. Accountability measures in schools were found to include scrutiny of all aspects of teachers' work, unreasonable pressure to meet attainment targets and requirements for greater uniformity of practice. These measures have achieved government aims of an increased focus on literacy and numeracy, at the cost of

reduced opportunities for creativity and a narrowing of the curriculum (Hutchings, 2015). Significantly, some teachers in Hutchings' study reported that the pressure to improve test outcomes and their own increased workload and stress had reduced the quality of their relationships with pupils

Alongside their responsibilities for academic learning, attainment and myriad administrative tasks, schools and teachers increasingly are required to deliver interventions that promote the physical, social and mental wellbeing of children. The arguable ambiguity in teachers' roles has previously been linked to teachers' poor mental health and wellbeing (Travers and Cooper, 1993; Hutchings, 2015). Interventions in schools have included those aimed at tackling childhood obesity, with healthy rating schemes for primary schools taken into account in Ofsted inspections (Gov.uk, 2018). In 2014, the National Institute for Health and Care Excellence recommended that teachers supervise nursery and primary pupils to brush their teeth up to twice daily. Schools are often expected to ensure pupils are sufficiently well fed and have been described as "the first line of defence against hunger" (Feedingbritain.org, 2020). Since 2015, all schools have had a duty to safeguard children from radicalisation and extremism under the Prevent strategy. Other duties school staff hold in relation to crime prevention include the searching and confiscation of drugs or weapons and the identification of pupils who are vulnerable to criminal exploitation in the form of County Lines. More recently, the Home Office proposed that school staff should hold a legal, public health duty to raise concerns about children at risk of becoming involved with knife crime (Bulman, 2019). The breadth of these duties, across a wide range of societal issues, is an indication of the complexity of the teaching role and how it may overlap with those of many other professionals.

1.6.2 Teacher mental health

In the Education Support Partnership's 2019 Wellbeing Index involving 3,019 education professionals, 72% of respondents reported feeling stressed, 34% had experienced a mental health issue in the past year and 57% had considered leaving the profession over the past two years due to pressures on their health and wellbeing.

Teachers themselves are consistently reported to be at increased risk of developing common mental health conditions compared to those in other occupations (Stansfeld et al., 2011; Kidger et al., 2016). In recent research which analysed data from over 20,000 teachers and education professionals, collected at different points between 1992 and 2018, it was found that around 5% of teachers in England state that they suffer from a long-lasting mental health problem, compared to just 1% in the 1990s (Nuffield Foundation, 2020). The study found, however, that this increase in reported mental health problems can also be observed in other professionals, including nurses and accountants. The researchers suggested that this increase could be due to greater awareness of, and willingness to seek help for, mental health issues. This was consistent with the team's finding that there has not been any increase or decrease in unhappiness, anxiety or low-self-worth amongst teachers over the last decade. In response to this research, the CEO of Education Support Partnership pointed out that they have seen an increase in the severity of symptoms that teachers are reporting to their helpline. In the Education Support Partnership's 2019 wellbeing index, education professionals scored an average of 44.7 on the 14-point Warwick Edinburgh Mental Wellbeing Scale, a lower score than the general population scores of 49.85 in England, 49.80 in Scotland, and 50.9 in Wales.

Poor teacher wellbeing may also be a problem for students. In a 2017 UK study, teachers showed high levels of work related stress due to time pressures and excessive workloads and it was concluded that this stress could impede their ability to provide effective early intervention emotional support for students (Palmer et al., 2017). In secondary schools, better teacher wellbeing has been found to be associated with better student wellbeing and low student psychological distress (Harding et al., 2019). The same study also found an association between teacher depression and higher student psychological distress.

1.6.3 Recruitment and retention.

Over the past two years there has been frequent media coverage of an emerging recruitment and retention crisis in the UK education sector, with concerns that the overall number of teachers is not increasing in line with growing pupil numbers. This apparent crisis appears to be having a greater impact on secondary schools, while the

primary school situation is deemed 'stable with some risks' (Worth and Van den Brand, 2019). The number of primary teachers grew between 2010 and 2017 in line with rising pupil numbers and the DfE's 2017-2018 Initial Teacher Training Census revealed that 106% of the government's primary school recruitment target was met and has been either nearly met or exceeded for the past 5 years. However, the number of primary teachers fell in 2017 – 2018, for the first time since 2010 (Vaughan, 2018) despite slight pupil growth, which could reflect funding constraints or slight primary teacher under-supply (Worth and Van den Brand, 2019).

The rate of primary teachers leaving the state sector has increased in recent years, particularly for working-age teachers, which suggests there may be some difficulty in retaining the expertise of experienced teachers in the classroom (Worth and Van den Brand, 2019). Between 2010 and 2015 the rate of working age primary school teachers leaving the profession each year increased from 8.9% to 10.3% and retention rates of early-career teachers have dropped significantly between 2012 and 2018 (Worth, 2018). Despite relatively strong recruitment and retention in primary schools overall, the increase in the rate of vacancies and temporarily-filled posts may indicate that some shortages are emerging (Worth and Van den Brand, 2019).

1.7 Summary of key issues

The introduction to this thesis has summarised issues relevant to child mental health and how these issues interact with the education system.

As well as being generally unhappier than their peers in other countries, diagnosable mental health issues among children and young people in the UK have increased in prevalence, accompanied by higher rates of self-harm and suicide. Increased testing and pressure on attainment in education has had a negative impact on pupil mental health, in addition to social media usage and worries about political, social, economic and environmental concerns. This illustrates the complex ranges of issues that teachers interact with in their roles.

With CAMHS experiencing an increase in demand, funding challenges and rising thresholds, accessing specialist support has become increasingly difficult. A number

of government policies and reviews have emphasised the need for a greater focus on prevention, timely access to support and further integration of services. The role of schools has been highlighted in several plans, including those which will involve training for teachers on the identification of child mental health issues.

Schools apply a range of whole school and individual approaches to the prevention and management of child mental health issues. Starting early with younger children, of primary school age, was one of the characteristics listed of more effective interventions. There have been some critiques of the assumptions and ideologies underlying mental health prevention in schools, highlighting the contradiction in making teachers responsible for pupil wellbeing while also telling them to deliver a national curriculum that limits teacher autonomy and input into their own specialisms.

Preventative approaches can operate at various levels, from individual to community and structural level interventions. However, it appears that the majority of interventions take place with individual children rather than with families and broader systems. These individual and small-group interventions include those which focus on the development of resilience and coping skills. Given that social inequalities are known to be a major risk factor in the development of mental health issues (WHO, 2014) and the Mental Health Foundation's 2020 report states that concurrent action is required at multiple levels in order to effectively reduce the prevalence of mental health problems, centring prevention around concepts such as resilience neglect to tackle the complex social, economic and environmental drivers of poor mental health and could be argued to place excessive responsibility on children.

Teachers are under significant pressure and the primary teaching profession is beginning to notice some difficulties with retention. There is some evidence that teachers appear to be at increased risk of mental health issues and links between poor teacher mental health and pupil psychological distress have been demonstrated.

1.8 Scoping review

A scoping review aims to identify key research in a topic area and determines the range of evidence that informs practice in a field, clarifies key concepts and identifies gaps in the research literature (Peters et al., 2015). A scoping, rather than a systematic, approach was selected for this study because the review was conducted with the aim of providing an overview of the existing literature.

1.8.1 Objective

The objective of the scoping review was to explore the current literature on UK school teachers' views on their role in the prevention of child mental health issues.

1.8.2 Inclusion Criteria

Inclusion criteria were created to determine the scope of the review. Only studies that involved the views of teachers in UK schools in relation to their role in child mental health were included in the scoping review. All quantitative and qualitative designs were included.

1.8.3 Search Strategy

The research strategy was carried out in several stages. First, I performed a limited search across databases to determine the relevant terms and index terms used. Then, using these identified keywords and index terms, I searched for published work across 6 electronic databases. I then searched the reference lists of identified papers to identify any further relevant work. All databases were searched from their start date to July 2019.

The search strategy consisted of four terms that were searched together using the Boolean operators 'or' and 'and':

1. 'teachers' or 'educational professionals'

AND

2. 'views' or 'perspectives' or 'experiences' or 'opinions' or 'beliefs' or 'attitudes' or 'perceptions'

AND

3. 'roles' or 'responsibilities' or 'duties'

AND

4. 'child mental health' or 'child wellbeing' or 'pupil mental health' or 'pupil wellbeing' or 'student mental health' or 'student wellbeing'

1.8.4 Databases

I searched the following 6 databases through EBSCOhost: Academic search complete, British Education Index, CINAHL Plus, ERIC, Psychinfo and Scopus.

1.8.5 Validation of Search Strategies

The search strategy was validated by choosing five papers from a key paper and seeing if the search strategy picked these known papers up. All five papers were picked up by the search.

1.8.6 Extracting and Charting the Results

All of the citations identified by the searches were downloaded using Mendeley reference management software. Duplicates were removed and the titles and abstracts were screened for relevance and potential inclusion in the review, using the inclusion and exclusion criteria. Full texts were obtained for potentially relevant papers.

1.8.7 Data Extraction and Management

A data extraction form was developed using scoping review guidelines (Peters et al., 2015). Data extracted included information about participants, the study design and outcomes relevant to the review.

1.8.8 Critical appraisal of reviewed studies

The reliability and rigour of the reviewed studies were considered drawing on Lockwood et al's (2015) critical appraisal criteria. These criteria include: the congruity between the study's methodology and objectives; the adequacy in representation of participants' voices; evidence of ethical approval and conclusions which flow from the analysis.

It was not possible to assess the reliability and rigour of one of the studies, an online poll (Anna Freud.org, 2017), because details of the study design were not publicly available. It was decided that this paper would be included in the scoping review due to the size of the sample and the relevance of the subject of the poll, whilst acknowledging that there is limited information to allow an assessment of the quality of this data.

The remaining eight studies appear to be of a broadly good quality. There is congruity between their objectives and chosen methodologies and conclusions appear to be based on research data. Illustrations from the data are provided which show the basis of conclusions and ensures that participants' voices are represented (Lockwood et al., 2015). Many of the studies feature the views of self-selected participants or participants who were selected to participate by a Headteacher, which could indicate that the existing literature lacks the voices of teachers who do not have interest or experience in the area of child mental health. Some acknowledged that their participants worked in a specific geographical location, which may affect the data gathered and its transferability. Two studies (Kidger et al., 2010; Shelemy et al., 2019a) succeeded in purposively sampling participants to reflect different locations and socio-economic areas. Several of the studies acknowledged that all of the schools included were rated Good or Outstanding by Ofsted. Two studies (Shelemy et al, 2019a and Shelemy et al, 2019b) specified that they had followed recognised criteria for rigour in qualitative research and completed an established checklist. Four of the 8 studies included an acknowledgement of the role of the researcher and a discussion around reflexivity.

1.8.9 Results

After importing all citations to Mendeley and removing duplicates, 576 records were identified. After inspecting titles and abstracts, 500 papers were removed, and full texts were retrieved for the remaining 76 papers. A further three papers were added through hand searching reference lists, searching grey literature and citation snowballing. After excluding 70 papers using the exclusion criteria, 9 studies met the inclusion criteria and remained in the final review.

The 9 included studies were all published between 2004 and 2019 and all featured teachers working in UK schools. Five of the studies focused on the views of primary school teachers, 3 featured secondary school teachers and 1 included a combination. Studies involving UK secondary school teachers were included because there will likely be shared broader context and crossover between secondary and primary settings. Two of the primary school studies utilised qualitative methodology, 2 followed a quantitative approach and 1 used a mixed methods approach. The combined primary and secondary study followed a qualitative approach. All 3 of the secondary school studies utilised qualitative methodology. Below, the studies have been grouped into secondary and primary school studies, to help distinguish which issues may differ or be more pertinent to teachers working with the primary school age group, which is the focus of the current research. The combined primary and secondary study has been grouped with the secondary studies because the majority of the participants worked in secondary schools.

1.8.10 Secondary and mixed studies

Rothi et al. (2008) interviewed teachers working in English schools to explore their self-perceived duty and competency in the recognition and management of pupils with mental health problems. Of the 30 teachers interviewed, 8 taught in primary schools, 13 in secondary schools, 8 in special schools and 1 in a Montessori school. The findings indicated that all of the teachers accepted that they had a degree of responsibility to care for the mental wellbeing of pupils but many were concerned by the changing nature of their responsibilities and felt inadequately prepared to

manage pupils with mental health needs. The participants highlighted the negative impact of pupils' mental health problems on their workload, job satisfaction and their own psychological wellbeing. They expressed concern about their distressed pupils and reported feelings of incompetence, frustration and helplessness. Many were concerned by the possibility that mental health problems could go unnoticed by teachers and some indicated that teachers felt incompetent in the task of recognition. While participants felt confident that they could identify pupils who were experiencing difficulties and who may require further support, they were often unsure as to whether the observations that instigated their concerns constituted a mental health problem.

A general lack of policy or strategies in the management of mental health problems in schools was commented on. The need for mental health training emerged as an important but complex issue and revealed mixed feelings about existing models of training and the likelihood of appropriate implementation in existing educational contexts. In particular, participants expressed a desire for expert advice on recognition of mental health issues and training that would help develop their recognition skills and their practical teaching and management strategies.

An additional finding of interest in Rothi et al.'s 2008 study was that the teacher participants tended to avoid using psychiatric language. Participants robustly asserted that they are not mental health experts and that the use of clinical terminology is not provided within teacher training. Some of the participants expressed concern that the use of psychiatric terminology in the classroom could result in the labelling, stigmatisation and marginalisation of pupils.

Importantly, many of the participants in Rothi et al.'s study expressed concern about a perceived steady encroachment on their pedagogic role by additional mental health care responsibilities. Nonetheless, they accepted that the rise in mental health difficulties among children and young people required a change in school practices and teacher training.

Kidger et al (2010) explored secondary school staff views on supporting student mental health and wellbeing, interviewing 14 staff members from 8 secondary

schools in England. A key theme amongst participants' responses was a strongly held belief that teaching and wellbeing are inevitably linked. Participants expressed that they were happy with the role that they were required to play in identifying vulnerable pupils and providing support where needed. However, they did not feel that clear guidance was consistently available. They expressed concern that teachers' own emotional health needs are neglected, leaving them unable or unwilling to consider those of students. The researchers argued that the findings endorsed a whole-school approach to emotional health, with a focus on teachers' training and support needs.

Shelemy et al (2019a) conducted 9 focus groups with UK secondary school teachers. Of the 49 participants, 67% had never received mental health training. The focus groups covered the needs and opinions of teachers regarding the mental health provision within secondary schools and the current methodology of mental health training. Participants expressed their wish for training on how to identify and provide early support for students who are struggling, without adopting the perceived role of a therapist.

Participants from Shelemy et al.'s focus groups consistently referred to a societal expectation that they have responsibility for the wellbeing of their students. In conflict with this expectation, many of the participants argued that they considered their role to be purely academic and believed that it would be preferable for 'experts with appropriate training' to provide mental health support to students. All of the focus groups emphasised that training should not include therapeutic strategies to improve a young person's mental health and that the role of the teacher should not be seen as that of a therapist or social worker. Participants stated that their role should be seen as educational and preventative. They expressed the view that any training for teachers should focus on how to educate students around mental health, ideally before the onset of mental health problems.

Participants in Shelemy et al's study (2019a) also discussed the need for training to help them identify whether a student is at risk and whether their mental health or behaviour is a cause for concern. Whilst many participants felt comfortable with identifying visible signs, such as self-harm, many wanted guidance on more subtle

indications. A repeated suggestion across the focus groups was to have a list of key indicators to help with identification. Participants emphasised the need for practical, interactive and expert-led training that provides adaptable resources. Participants expressed a desire to prevent students' mental health from worsening. When encountering a student who is struggling, many of the participants described how they would use their 'common sense and instinct' to try and help. As in Rothi et al.'s 2008 study, some expressed uncertainty about their responses to students. Participants pointed out that without guidance, their responses could inadvertently worsen a students' mental health or exacerbate issues which may otherwise resolve themselves. One reflected "we don't know when to leave things or when to let things go or when to intervene. Do we make things worse? Are we making something out of which is in fact a natural progression?" Collectively, participants wanted advice on the 'correct' and 'incorrect' things to say and do to help students.

Several of the focus group participants emphasised the need for parents to be made aware of young people's mental health issues and described how parents could be dismissive of their child's mental health problems. The teachers expressed a desire to learn how they could educate and inform parents helpfully. Participants also commented on the need for better communication with external CAMHS services, as well as guidance on what makes a successful within-school mental health communication strategy.

In a further study, Shelemy et al. (2019b) interviewed 7 UK secondary school teachers about their experiences supporting the mental health of students. Participants were asked to think about a specific incident where they had supported a student who was struggling with mental health difficulties. In their responses, participants described their role as being a balancing act between adequately providing support and potentially becoming too close to a student. All acknowledged that they did not want to act as a therapist and viewed their primary role as that of educator. Participants shared their concerns that they could be giving incorrect advice if they were to advise students. They emphasised the importance of trust in building positive relationships with students. Some indicated a lack of clarity around the extent of their caregiving responsibilities. Others spoke about their responsibility to provide stable care and suggested they act in place of parents whilst the child is

at school. All of the participants listed the pressures of time and space in schools and the over-burdening of specialist services as barriers to adequate student support. Some participants described how parents' own beliefs and cultural views about mental health had prevented some students from accessing appropriate support. Unanimously, participants reported a lack of understanding and knowledge about how best to help and referred to a lack of mental health training for teachers. Many described feelings of helplessness and frustration in relation to the limited support they felt able to provide students.

1.8.11 Primary school studies

Gowers et al (2004) received 186 responses to a questionnaire distributed to primary schools in South Cheshire. Of these respondents, 165 had responsibilities as SENCOs. The questionnaire included an investigation of teachers' contribution to the identification, management and referral of children with mental health problems. Fifty per cent of the respondents claimed to 'rarely or never' teach children with mental health problems, which raised a query about rates or detection and whether children whose problems are quieter in nature may be overlooked in a busy school environment. The teachers expressed interest in children's mental health, which they stated had significantly impacted on their teaching. They had received little training on the subject and over half felt that their knowledge and understanding were inadequate. The teachers in the study were almost unanimously keen for further training. Gowers et al. argued that, to contribute effectively to CAMHS, primary school staff need to be able to provide: screening and identification of children at risk; observations; liaison with professionals in specialist services; interventions and behavioural management relevant to their teaching role.

In a 2017 online poll, commissioned by the Anna Freud National Centre for Children and Families, primary school teachers shared their views on mental health in primary schools. Of the 330 respondents, 92% agreed that primary schools have a crucial role to play in the identification of pupils who have mental health problems but only 42% felt confident they would know which organisations to approach to help pupils who have mental health problems. When asked if mental health should be a

compulsory topic of education within all primary schools 72% of respondents agreed that it should be. However, 41% stated they had either never taught a class on mental health or had not taught one in the past year or could not recall when they had taught one. More than half of the primary school teachers (54%) did not feel adequately trained in supporting pupils with mental health problems, with only 10% strongly agreeing that they had the necessary training to feel confident about what action to take when a child experiences a mental health problem.

Across six English primary schools Harrap (2016) carried out interviews with 8 teachers and collated questionnaire responses from 31, with the aim of exploring primary school teachers' knowledge and understanding of child mental health. The questionnaire findings indicated that the majority of primary school teachers had not received specific training about child mental health and experienced uncertainty and confusion around the topic. In the interviews, participants expressed their view that child mental health issues are difficult to identify and pointed out the vague nature of the term 'mental health'. They voiced uncertainty about how to distinguish child mental health issues from typical psychological experiences. As a result, teachers were unsure about how they should respond to different children. Participants indicated that they used friends' and families' mental health issues as frames of reference to attempt to identify children with similar needs in their classrooms and raised concern about the subjectivity of this approach. Whilst expressing their appreciation for peer support and learning, participants also highlighted the need for expert support.

Cooke et al. (2016) conducted interviews with 15 primary school teachers from three schools in London and Brighton. The interviews focused on the extent and nature of teachers' communication with pupils about mental health, the factors that affected this communication and ideas regarding how this topic might best be taught. Strikingly, discussions about mental health problems appeared to be almost completely absent from the classrooms of the teachers involved. Teachers expressed several fears about what might happen if they were to speak to children about mental health problems. They feared complaints from parents and were concerned that discussing mental health problems would upset children, result in children worrying that they had a particular problem or trying out undesirable

behaviours. Some participants suggested that primary school children were too young to learn about mental health problems. Many of the participants felt that they did not have the requisite knowledge and skills to talk to children about mental health and some were worried that discussions on the topic might generate questions that they could not adequately answer. A belief that expert knowledge was necessary to have such discussions was expressed often. Some of the teachers saw mental health problems as more commonly affecting adults and therefore less relevant to children. Some pointed out that labelling children is unhelpful and should be avoided and commented on the stigmatisation of mental health problems.

Primary teacher participants in Cooke et al.'s study (2016) shared their belief that mental health problems are difficult to teach and difficult for children to understand. They stressed the need to adhere to the national curriculum and pointed out that mental health problems did not feature in this. They shared their view that teachers are not trained to teach about mental health problems, therefore they should not attempt to do so. As was found in similar studies, participants felt they lacked sufficient knowledge to talk to children about the subject of mental health. Participants wanted training about mental health problems, including knowledge about types of problems and their causes. They also felt that they needed guidance on what was appropriate for them to discuss with children. Participants believed that their role was to notice 'abnormal' behaviours or emotions and, consequently, to make referrals to other professionals. Some of the participants thought that teaching children about mental health problems was not within a teacher's role and that school management should bring in experts to deliver the topic. Others felt that the responsibility for mental health education lay with parents.

Danby and Hamilton (2016) gathered the views of 18 education practitioners across two Welsh primary schools. Participants consisted of 9 teachers, 7 teaching assistants and 2 additional learning co-ordinators. 14 questionnaires and 7 interviews were completed, with questions focused on gaining insight into how children's mental health and wellbeing was understood, supported and promoted. The findings indicated a reluctance to address mental health topics due to a fear of stigma and a desire to protect children. Responses conveyed how issues relating to

funding, skills, training and over-stretched specialist services are making it difficult for school practitioners to support primary pupils.

Most of the participants in Danby and Hamilton's study appeared to be aligned with a social model of mental health, perceiving the wellbeing of children to be a result of the complex interplay between personal, social, economic and environmental factors. Participants were unanimous in the opinion that the term mental health was unsuitable for use with children. They expressed concerns that children would form negative interpretations linked to illness or abnormality and believed that language which centres on emotions was more child friendly and appropriate.

All of the educational practitioners in Danby and Hamilton's study believed school staff, with their knowledge of children's development and wellbeing, are well placed to support children's mental wellbeing. Nine out of the 14 participants commented that the role of the school should be to provide a 'safe', 'caring' and 'supportive' environment. When discussing their roles in relation to children's wellbeing, many participants spoke of promoting an understanding of risk factors, exploring feelings and developing resilience among children. Other roles included working with parents and specialist services to provide intervention for those with more complex needs. Some discussed how they might be the first person to notice whether a child is experiencing mental health issues. Responses to the questionnaire indicated that the majority of participants felt confident in their ability to identify when children require support with their mental health and confident in their ability to provide this support. Knowledge of available support services, the role of specialist services and the skills required to promote mental wellbeing as a whole school policy were highlighted as areas for development.

1.8.12 Summary of existing literature

The quality of the existing UK based literature is broadly good with some limitations identified around transferability and self-selection bias. Participants in the existing literature have described dilemmas that arise in their role supporting the mental health of children and young people. Many of the teachers and educational professionals communicated that whilst they feel a sense of responsibility to care

for pupil wellbeing, they feel inadequately prepared to respond to the needs of pupils who have mental health difficulties. A lack of relevant training and the scarcity of internal and external resources were frequently cited as issues faced by both primary and secondary school staff. Some of the studies indicated that teachers lack confidence in identifying what constitutes a child mental health issue and how this is distinguishable from typical childhood psychological experiences, whereas others suggested that teachers feel competent in the identification aspect of their role. Many of the teachers, across primary and secondary settings, stated a desire for expert advice and guidance and wished for training in the identification and understanding of mental health issues. Feelings of incompetence, frustration and helplessness were expressed in several of the existing studies. In one study, participants discussed how secondary school staff's own mental health needs were neglected, leaving them less able or willing to consider the mental health needs of students (Kidger et al., 2010).

Several of the existing studies referred to the participants' assertion that their role should be educational and preventative, rather than in place of therapy or social care. Some of the teachers in one secondary school study (Shelemy et al., 2019a) commented on the conflict between the societal expectation that they hold responsibility for children's wellbeing and their own perception of their role as purely academic. A lack of clarity around the nature and extent of teachers' responsibilities in relation to child and adolescent mental health was referred to in many studies. This lack of clarity and the increasing breadth of the teaching role were areas of concern for many participants.

In the existing literature, primary school staff described their role as having an understanding of mental health risk factors and supporting children to explore their feelings and develop resilience. The role of the school, in providing a safe and supportive environment, was also noted. Some of the concerns raised in the literature were specific to the primary school studies. These included a concern that primary school age children are too young to learn about the topic of mental health and a fear that this could cause them distress. Some primary school teachers perceived the topic to be difficult to teach and challenging for children to comprehend. Additionally, some participants feared complaints from parents.

Others expressed the concern that labelling children with mental health problems could be problematic and stigmatising.

1.9 Justification and Aims

1.9.1 Clinical relevance

With 50% of all lifetime cases of mental health problems established by the age of 14 (Kessler et al., 2005) and emotional health in childhood cited as the most important indicator of life satisfaction and personal outcomes in adulthood (Leyard et al., 2013), prompt, effective intervention and prevention of child mental health problems is of utmost importance. With an increasingly stretched CAMHS provision and more emphasis on targeted and universal approaches in schools, there is a growing expectation that teachers will receive mental health training and implement mental health interventions as part of their role. Primary school teachers' views are of particular relevance because of their potential to identify children for whom early intervention may be most beneficial. However, the existing literature has indicated that teachers working with primary age pupils may be wary of identifying children's difficulties as mental health issues and concerned about the impact of talking to children about mental health. Younger children may find it more difficult to articulate their distress and, given the high rates of unhappiness amongst UK children, professionals face dilemmas in distinguishing mental health concerns from common emotional experiences.

It could be argued that, with limited mental health provision across the country and the time children spend in schools, it is crucial to harness existing resources and equip teachers to provide effective, preventative support for children and young people. Teachers have been cited as the most likely source of support for parents with concerns about their child's mental health (Newlove and Delgado, 2015). However, this additional burden on teachers can contribute to increased pressures on staff time and school resources (Snell et al., 2013). When considering the pressures on teachers' workloads and the numbers contemplating leaving the profession, further expanding teachers' roles and responsibilities to encompass mental health support may be inadvisable.

Teacher's views and beliefs about their role in prevention are of significance to children who receive school based interventions and to services and professionals, including Clinical Psychologists, who provide intervention and consultation for children and staff in educational settings. With the recent government mental health prevention plan and the creation of school Mental Health Support Teams, there may be increased interaction between teachers and mental health clinicians and further changes to schools' responsibilities around mental health.

1.9.2 Gaps in literature

While there are a substantial number of studies that explore various aspects of mental health interventions in schools, there appears to be a paucity of research featuring teachers' perspectives on the roles they are being asked to fulfil in mental health prevention. The majority of the literature that includes teachers' views on child mental health and relevant issues is of American or Australian origin and this body of literature cannot be reliably generalised to the UK context (Cheney et al., 2014). The existing UK literature that includes the perspectives of primary school teachers does not hold a specific focus on prevention and, with much of it published in 2016, may not provide an accurate reflection of British primary school teachers' current experiences and understandings following recent developments in government guidance and policy. The complexity of the issues identified and the uncertainties and dilemmas teachers face indicate that further qualitative research in this area, to allow exploration of perspectives and understandings, would be of value.

1.9.3 Aims of proposed study

The proposed study aims to increase understanding of the perspectives of primary school teachers on their role in the prevention of mental health issues in pupils. The study aims to gain insight into the dilemmas, challenges and opportunities teachers are presented with when working within a context where there is an increased emphasis on prevention and early intervention in schools.

The study aims to explore the following questions:

- What are primary school teachers' views on the roles they are being asked to perform in the prevention of mental health issues in pupils?
- What helps primary school teachers in their role in the prevention of mental health issues in pupils?
- What hinders primary school teachers in their role in the prevention of mental health issues in pupils?

2. METHODOLOGY

2.1 Epistemological Position

Epistemology refers to the theory of knowledge and is concerned with how we can know and what we can know (Chamberlain, 2015). This study adopted a critical realist epistemological stance, maintaining focus on the data and the reality of the education system whilst considering the limits of reality and how social discourses and broader social context influence our construction of meaning. A critical realist epistemological position acknowledges the co-existence of a material reality and human agency and recognises the subjective element in knowledge production (Willig, 2008). It contends that a material world exists but direct access to it cannot be obtained due to its interconnectedness with a fluid, ever-changing social world (Cruickshank, 2003). This epistemological position, therefore, assumes that real events occur but that "each person experiences and gives meaning to events in light of his or her own biography or experiences" (Corbin and Strauss, 2008). These meanings are constructed by both the research participants and the researcher. Critical realism acknowledges that there are likely to be a diverse range of potential interpretations of research data and no single interpretation can be considered the only appropriate version. As the researcher, I have held this principle in mind throughout the study and recognise it is important to consider what I might bring to the research context and how my own experiences may have influenced my analysis of the research data. Having worked in primary school settings and with primary school aged children prior to and during my clinical training, my interest in the views of primary school teachers has been informed by my experiences. I have

attempted to keep in mind and reflect on my assumptions throughout the research process. Whilst it is not possible to separate my own experiences from the research and analysis, by stating this limitation the reader can consider the results in relation to the researcher's relevant work experiences. This will be discussed further in the critical review section.

2.2 Thematic Analysis

The research data was analysed using the method of Thematic Analysis, an approach which facilitates the identification and analysis of patterns of meaning across data (Braun and Clarke, 2013). An inductive approach was used, aiming to generate an analysis from the data up, consistent with the explorative nature of the study. The following six stages of Thematic Analysis were adhered to, as outlined by Braun and Clarke (2013):

2.2.1 Familiarising self with the data

The first stage of the analysis began with a process of immersion in the data to become familiar with the content. This involved reading and re-reading the interview transcripts, taking note of items of potential interest. At this stage, preliminary themes were conceptualised and brief notes were made on the transcripts (see Appendix A) to aid the process of analysis.

2.2.2 Generating initial codes

Coding is a process of identifying and labelling aspects of the data that are relevant to the research question. This stage involved producing initial codes from the data by coding each transcript manually. Codes can either reflect the semantic content of the data or more conceptual, theoretical interpretations of the data (Braun and Clarke, 2013). I aimed to code inclusively and broadly to create a comprehensive set of codes that differentiates between different concepts, issues and ideas in the dataset (Braun and Clarke, 2013).

2.2.3 Searching for themes

After the data was coded, broader themes were identified. A theme represents a level of patterned response or meaning within the data set. In order to identify patterns, I reviewed the codes and the collated data with the aim of identifying similarity and overlap between codes. Codes that did not reoccur were not considered thematic (Buetow, 2010). Visual mapping was used to explore the relationship between codes and themes, subthemes and overarching themes (see Appendix B).

2.2.4 Reviewing themes

During this phase of the analysis, coded and collated data were re-read to check that the identified themes were representative of the data set. A final re-read of all data items was carried out to ensure that the themes captured the meaning of the dataset in relation to the research questions. During this stage of the analysis themes were confirmed, revised or rejected.

2.2.5 Defining themes

Each theme was named and the focus and boundaries of each theme was defined. At this stage, I considered how each theme fits into the broader narrative in relation to the research questions. I aimed to ensure that each theme has a clear scope and purpose, is relatively discrete and, when combined, provide a rich, coherent and meaningful representation of the dominant patterns in the data.

2.2.6 Final analysis

A final summary of the themes is described in the results chapter.

2.3 Ethical Considerations and Confidentiality

2.3.1 Ethical Approval

The University of East London's School of Psychology Ethics Committee provided ethical approval for the study in July 2019 (see Appendix C).

2.3.2 Informed Consent

Participants were provided with participant information sheets (see Appendix D) and an opportunity to ask questions and discuss the study with me prior to their participation in the interview. Once participants were ready to proceed, written consent was obtained on the consent form (see Appendix E). On the consent form, participants were provided with assurances of confidentiality and their right to withdraw from the study.

2.3.3 Confidentiality

Prior to the interview, confidentiality and its exceptions were highlighted both verbally and in writing, on the participant information sheet (Appendix D) and the consent form (Appendix E). All interviews and transcripts were anonymised by assigning a participant number to each interview. During the transcription process, any identifiable information was amended by the researcher.

The study data was accessed only by the researcher and only anonymised data was shared with the research supervisor. The study data, including audio-recordings and transcripts, was stored on a password protected computer which was accessible only by the researcher. Audio recordings were then deleted from the researcher's recording device. Consent forms were stored on the researcher's personal space on the UEL OneDrive for Business server and paper versions were then shredded.

2.4 Materials

A standardised email including the information sheet was sent to potential participants to introduce the project. The consent form was then shared with participants prior to the interview. During the semi-structured interview, an interview schedule was used as a guide. Interviews were audio recorded using a digital voice recorder.

2.4.1 Development of the interview schedule

The development of the interview schedule (see Appendix F) was informed by a review of the literature, the research aims and my professional experiences. The interview schedule included indirect questions “Can you tell me about your understanding of primary school teachers’ roles in the prevention of child mental health issues?”, direct questions “Has that changed during your time teaching?” and follow up questions “Could you tell me a bit more about that?”. After listening to the recording of the first interview I reflected on the interview schedule and areas where it would be useful to probe further in future interviews, increasing the use of prompts and follow up questions to encourage participants to elaborate on their responses. This facilitated a greater breadth and depth of discussion in future interviews. Prior to the interview questions, participants were asked some questions about their current role and the number of years they have been teaching. The semi-structured nature of the interview schedule allowed opportunity to prompt participants to expand on their experiences and perspectives. I aimed to not restrict participants with closed questions, but create space to hear individual accounts in depth to facilitate understanding. I was mindful to not stray too far from the interview schedule in order to answer the research questions.

2.5 Participants

A total of 11 primary school teachers participated in the research. This sample size was viewed as appropriate due to the study’s aim of conducting an in-depth analysis of the data. To adhere to the inclusion criteria, participants were all qualified teachers with experience of working in UK mainstream state primary schools. Nine of the participants were female and two were male. Participants’ years since qualification ranged from 8 to 40, with a mean of 14 years. Many of the teachers had worked across multiple year groups during their careers and between them held experience of teaching classes from foundation stage (ages 4-5) up to year 6 (age 10-11, the final year of primary education). Participants worked across a total of 10 UK mainstream state primary schools located in 6 English counties. Nine participants worked in schools in London and its surrounding counties. To ensure anonymity, I have not included further geographical information about the participants or schools.

2.6 Procedure

2.6.1 Recruitment

Initial contact was made with 7 primary school teachers already known to the researcher. These teachers were sent the participant information sheet via email, asked if they would be willing to participate in an interview and to share the information with a current or former colleague. Six of the known primary school teachers were able to participate within the time-frame and a further 5 were recruited using the snowballing approach. It was made clear during recruitment that interviews could take place face to face or via telephone, in or outside of working hours.

2.6.2 Interviews

In total, 11 interviews were completed between August and September 2019. Five of these were conducted face-to-face and six by telephone. Face to face interviews were conducted in quiet, private spaces in community settings. The interviews ranged between 24 minutes and 15 seconds to 1 hour, 12 minutes and 58 seconds (with a mean duration of 40 minutes and 70 seconds). All interviews were audio recorded using a digital voice recorder. I introduced myself to participants as a clinical psychologist in doctoral training and reiterated the purpose of the study, details around confidentiality and their right to withdraw. Participants then signed a consent form. The semi-structured nature of the interview allowed me to probe new lines of inquiry that surfaced (Payne and Payne, 2006) and provided participants with the flexibility to elaborate on their responses.

2.6.3 Transcription

Following each interview, I transcribed the audio file verbatim. Non-linguistic features of speech, such as pauses, sounds, coughs, were not recorded in detail because the research aimed only to examine the content of the interviews (Willig, 2008). Each line of the transcript was numbered and double spaced to allow annotations to be made and referenced. The transcription process provided an opportunity to familiarise myself with the interview data. Once each transcript was

completed it was checked against the audio recording to ensure accuracy, which provided further opportunity to gain familiarity with the data.

2.6.4 Reliability and Validity

In line with a critical realist stance, I recognised that my views, position and experiences may influence the analysis. To pay attention to the biases I brought, I utilised a self-reflexive journal where I noted my interests, assumptions and experiences which may have influenced how I viewed the data. As recommended by Hamberg and Johansson (1999), reactions during and after the interviews, transcription and analysis were recorded. To increase the credibility of the analysis, extracts from the transcripts were shown to my thesis supervisor who then shared his observations and interpretations. We further reviewed the codes and themes across the data together, as a 'verification step', reviewing the analysis for discrepancies, corrections and elaborations in accordance with good practice (Elliot et al., 1999)

2.6.5 Reflexivity

As with other forms of qualitative research, thematic analysis requires the researcher to reflexively consider the impact of their own experiences, beliefs and assumptions on the research process (Braun et al., 2015). As a trainee clinical psychologist I hold a professional interest in the mental health of children and young people and throughout the research period I worked in NHS child and adolescent mental health services. In my work experiences prior to clinical training, I spent time working within a range of education settings as well as in roles which involved consultation and training for school staff. Throughout the research process I attempted to remain aware of how my experiences and position may affect the data analysis. I will consider further my reflections on my position in relation to the research in the critical review section of this thesis.

3. RESULTS

3.1 Results overview

Following the Thematic Analysis of the interview data, findings were grouped into themes and subthemes, as summarised in Table 1:

Table 1: Interview data themes and subthemes

Themes	Subthemes
Understandings of child mental health.	<ul style="list-style-type: none">• Causes of child mental health issues.• Blurred line between health and illness.• Disparity between prevalence and specialist resource.
School's place in society; teacher roles and responsibilities.	<ul style="list-style-type: none">• Changing expectations imposed on teachers.• Home and school; who holds responsibility?• Expertise deficit.

3.2 Understandings of child mental health

3.2.1 Causes of child mental health issues

This first subtheme considers participants' understanding of the causes of child mental health issues, highlighting the role of socio-economic status, family context, social media and the pressure to achieve. Issues with the current national curriculum for primary schools are discussed, including how the content and structure of the school day can impact negatively on child mental health.

Many of the teachers discussed the interaction between a child's mental health and the financial position of their family. Some shared their observations of children from lower income families having more limited access to social and recreational activities and differing stresses and pressures than children in higher income

families. The following participant's response suggests that children can be aware of the difference in wealth between them and their peers and the signifiers of this, such as 'hand me down clothes'. This comparison and awareness of difference can be a source of anxiety. As well as the link between poverty, hunger and anxiety, this response also raises the issue of children's varied access to opportunity and resource, dependant on the socio-economic status of the family:

"some children from kind of, low..poorer backgrounds will have a lot of..more different stresses and pressures on them than children from a more affluent background. I think, with regards to, just..something as simple as time spent doing things other than being in the family home..a child playing for a sports team may have anxieties around being the best in that team or struggling around um kind of their ability in that respect, whereas a child who doesn't have that opportunity to play for a sports team or, um, have training in something, have horse riding lessons...they will struggle with different things, maybe the fact, you know, that they're hungry a lot of the time, perhaps they haven't had the opportunity to..they know their friends are going to the beach, they've got hand me down clothes, those sorts of things, those anxieties will affect them more...smaller things around that, that sort of contribute to children's mental health I think." (Participant 11, 381)

Family structure, parental discord, financial and health issues in families were also noted as having negative impacts on child wellbeing by many of the teachers, who have noticed children presenting as tired and anxious and linked this to their home circumstances:

"if both parents are working..and then you get children coming in quite tired..on the Monday as well, where they've had a really busy weekend, um, and so..sort of, and then you've got the children that maybe mum and dad don't live together so they're having to do sort of split lives and they get sort of quite panicky over when they've left homework at another parent's house or their P.E kit or if mum and dad aren't talking, or if mum and dad have had an

¹ All quotations are followed by participant number and line number of quotation

argument, um, so I think it's just sort of..their whole chaotic life" (Participant 10, 72)

"whether that's in the process of family break-down erm... there's also been financial issues and health issues and mental health issues of parents that have erm impacted on children's mental health" (Participant 2, 123)

Some responses indicated that teachers identify links between disruption, violence and addiction in homes and levels of anxiety and self-esteem in children. The use of the terms 'vulnerable' and 'broken' in the following extract indicate an understanding of child mental health issues as occurring predominantly outside of the confines of a conventional model of family life:

"the majority of mental health things we deal with come from children from vulnerable families and it tends to be linked to home life....so quite often, children who've come from broken families where there are negative relationships in the home, there might be domestic violence going on, addictions and things like that, those children we find quite often suffer with anxiety..they might show patterns of um..you know, like control issues and things like that um..low self-esteem, lots of those kinds of things, um, yeah and we tend to find there's usually reasons in the family background" (Participant 1, 14)

Another referred to how an absence of social care provision has increased the burden on schools and the need for teachers to fulfil roles traditionally associated with parents and other professionals. The need for school to step in and provide children with clothing, food and transport is seen as impacting negatively on children's mental health, perhaps due to the stigma of this or the uncertainty of where their basic needs will be met. There is an implication that children are at risk of falling between the gaps in available provision, with their needs going unidentified and unaddressed without school's input:

“for children as well who perhaps should be under social services care or at least under their watch and haven’t been, erm..err and are looked after by various people in school and become very involved with, with the families because it’s not entirely clear who family members are, who children are living with and then often these children need to be err...erm clothed and fed and transported by school erm..and, yeah that’s having a huge impact on their mental health.” (Participant 2, 126)

One participant shared their observation that the connection between socio-economic status and child wellbeing may not be straightforward, with children from a range of backgrounds facing a form of emotional deprivation as a result of a lack of parental presence and an over-reliance on electronic devices in place of parental attention, nurture and care:

“children sort of, with both parents working..and sort of, I think, left to sort of entertain themselves through like iPads and their mobile phones, um, and it just feels at times that even though these children, some of them have very sort of privileged backgrounds, um, and with sort of materialistic things, you can also see them just wanting sort of to be looked after and cared for..but cus of how life is, it’s just so busy” (Participant 10, 65)

Several of the teachers commented on the relevance of peer relationship issues, the pervasive nature of social media and the impact of this on child mental health, little opportunity for respite from these external pressures:

“with the older children we work with, um, peer pressures, the introduction of social media..and children having anxiety around things like that” (Participant 1, 12)

“you get some other children then worrying about what’s going to happen over the weekend on a messaging site or on a group chat, um, which is something..there’s not escape then from, from that and it must be really tricky as a child, um, to sort of have a break away from it.” (Participant 10, 121)

Teachers' interactions with pupils on the topic of social media use suggests indistinct boundaries between school and home, which will be discussed further later on in this chapter. This overlap between school and home is also referred to in the extract below, with the mention of tuition. The pressure on children to achieve, imposed by parents and the education system, was referred to as a further negative influence on child mental health:

"I feel that, actually, at primary school there's a lot of pressure on children to do well, um, and that's not just from the school that's from the parents, um, as well with their children, um, and getting them extra tuition and things like that at, at an early age, so I feel it's those things that also contribute to, um, how it affects children's mental health." (Participant 10, 11)

Several participants referred to issues with the current national curriculum. The pace of delivery, high expectations and the vast content lead to overloaded children and teachers, leaving minimal opportunities for nurture, thought and reflection. Responses indicated that a typical primary school day allows insufficient time for the conversations and relationship building required to effectively support pupil mental health, with pupil attainment seeming to take precedence over pupil wellbeing:

"the curriculum more than anything I think..that's the main obstacle, you know especially..I have worked briefly with year 2s and you're on a treadmill, you're like a hamster on a wheel it's like go go go go go..it's almost as if the children don't matter any more" (Participant 3, 223)

"there's only a certain amount of time you can ever give to individual children to talk about any of these areas because of the pressures of the curriculum and the expectations on schools to be achieving in every area umm...unfortunately it just isn't really something we have the time for, so unless a child is open in coming to us with anything, it's very difficult to find out what is going on in a child's life" (Participant 1, 201)

There was a sense of teachers' hands being tied, that they could see the damage caused by the expectations imposed on children and teachers but are required to deliver the curriculum regardless. Although teachers may witness children

struggling to cope with the demands and structure of the primary school day and perceive the curriculum as detrimental to child mental health, they can lack the power to intervene or work with autonomy:

“the way that teachers teach, that sort of one thing after the other, that I think impacts anyway on mental health but..you know some children you can see just can’t cope with the speed of things going..they don’t have time to process one lesson to the next...I’ve seen it impact negatively on some children..oh it’s heartbreaking, you just want to stop and say let’s just not do maths now, let’s paint a picture or play with the Lego..some children just cannot cope with it..that structure.....and these are little children, their childhood’s being taken away from them really...you know you’ve got that expectations and you know, it’s quarter to 11 and you’ve got to be doing maths for 30 minutes and then it stops and then..you know, and even the bells and the buzzers in the school..impact because you know, it’s that time, it’s that pressure of time”
(Participant 3, 229)

Some of the teachers expressed frustration with how they are being asked to teach and assess children. The following participant’s response highlights the inherent contradiction in being asked to promote mental health awareness as part of a problematic curriculum and overloaded school system. This extract also speaks to the conflict between individual professional values and the demands imposed by government education policy, with an indication that existing or suggested approaches to mental health prevention neglect to address the stark, fundamental issues in the education system:

“one of those frustrating government policies..that totally contradict itself in nature, and it’s sort of saying, teachers will teach mental health or awareness of mental health, while at the same time they’re producing a curriculum that is damaging children’s mental health and asking us to deliver it..so it’s one of those really frustrating things whereby the pressures on children have never been greater, the curriculum has never been harder, they are being asked to know more, to do more and they, their minds are busy..their extra-curricular activity levels are down, they are really under a lot of pressure for young children and you sort of want to go..well maybe you could look at that, when

thinking about children's mental wellbeing..offloading the testing and the, um, the, the sort of very archaic curriculum that they are putting forward that is sort of, erm, sucking the joy out of their learning, that would be a better way, in my mind, of helping, in a really practical way, children's mental health" (Participant 6, 331).

3.2.2 Blurred line between health and illness

This subtheme considers participants' conceptualisations of child mental health and how the boundaries between typical emotional responses, mental health issues and safeguarding concerns may be unclear.

Participants' responses indicated a lack of clarity around how mental health related distress can be distinguished from typical experiences of unhappiness or worry, or where experiences of sadness and anxiety may or may not suggest a diagnosable condition. Although some of the teachers appeared confident in their ability to identify children experiencing mental health issues, others expressed uncertainty about the boundary between health and illness:

Researcher: and what sort of indicators might you notice in your role as a teacher, indicators in terms of, um, mental health?

Participant: um I suppose kind of, erm, anxiety, you know, um, exhibiting, um, kind of behaviours that indicate, um, that they're anxious, erm, you know, erm, maybe if they're withdrawn, I suppose just, you know..the..if their behaviours aren't, um, mainly, not concerning but kind of like a little bit different to, um, others, other pupils in the class, erm, what else could it be..I don't know really" (Participant 9, 40)

When asked about training, information and support requirements, some expressed a desire for further training on this topic, including how to identify mental health concerns, indicators of mental wellbeing and information on where to go for further support and assistance:

Researcher: is there any further training, information or support related to child mental health that you think could be beneficial to teachers?"

Participant: "I guess you'd have to go right back to the beginning wouldn't you? What is good mental health, how do you know a child has good mental health you know..what do you do if a child is showing signs of mental health problems..you know, who can you seek support from..who, you know..if it goes back to safeguarding and..you know..and..who can you ask for help and..you know, not being able to necessarily let parents know and..yeah..so definitely some training would be good (Participant 5, 252)

There appeared to be a conceptual overlap between safeguarding issues and mental health issues. In response to questions about child mental health, several participants made reference to safeguarding processes:

Researcher: Could you tell me about your understanding of primary school teachers' roles in the prevention of child mental health issues?

Participant: "you've got the safeguarding aspect and obviously teachers have a statutory obligation to um..look after children's wellbeing on every level and um mental wellbeing comes into that as well..um..so I would say that, sort of, first and foremost um..the most important part is safeguarding (Participant 6, 55)

As discussed in the theme prior, family context, including abuse and neglect, was understood to be a relevant factor in the development of child mental health issues. Therefore, safeguarding issues may be inter-woven with mental health presentations in children, which may account for some of the conceptual overlap between safeguarding and mental health.

The following participant's reference to a MASH (multi-agency safeguarding hub) team also indicates some confusion about where teachers report concerns regarding pupils' mental health and the role and responsibility of social care in child mental health prevention:

Researcher: Could you tell me about the role that teachers play in the prevention of children's mental health issues...what teachers might do in their jobs to prevent mental health problems from developing in children?

Participant: "possibly there would be, um, external agencies who would get involved if we had noticed a child with mental health, um, the MASH team, the safeguarding team would speak to them with regards to mental health and try and get external agencies involved" (Participant 8, 67)

3.2.3 Disparity between prevalence and specialist resource

The third sub-theme explores a dearth of specialist provision for children experiencing mental health issues. The impact of funding cuts on multiple agencies and the implications of this for teachers' roles is considered.

Many of the participants recognised an increase in the mental health needs of pupils over the period in which they have been in the profession. They observed that this growth in need has been accompanied by an increasingly limited child mental health provision, with service thresholds rising and children's needs going unaddressed. This suggests that teachers may be left holding the emotional distress of their pupils in the absence of specialist intervention:

"I would say it's definitely become more prevalent, I think..I think we're aware of it becoming a bigger issue..I think..we have ways to deal with it, but at the same time, we're also really aware that there's less and less erm..erm..for these children to be referred to..it's not..it seemed to be increasingly more difficult for children to have a referral..have a CAMHS referral" (Participant 2, 324)

"we can call agencies in but they're already stretched, you know, like CAMHS is ridiculous, it's impossible to get a CAMHS referral for a child, it's impossible you know, we have children who have had horrific things happen to them that are crying out for CAMHS and even their needs are not great enough in order to get any support from CAMHS" (Participant 4, 244)

Some observed the impact of funding cuts on a range of services relevant to children and families, including voluntary sector resources:

“because funding has been cut so much, we..I’ve seen a massive change in the number of, um, kind of charities that social services can access that would help, the number of kind of, mental health things..mental health support that would help children” (Participant 7, 91)

Some responses depicted a frustrating position that teachers hold on the frontline, spending more time with children than any other profession and observing increasing levels of distress, yet feeling ill-equipped to respond to the level of need within a system in which it is difficult to access effective and timely support. One teacher shared their concern about the lack of follow-up when concerns about pupils’ mental health are reported:

“I suppose the frustrating thing is that um..we have always had an obligation to report anything..any niggle that we have about children we’ve always, I suppose maybe we report a little bit more now um..but I would say there’s definitely a sense that you can record these things that there isn’t a..there isn’t a great deal um that comes out of it in terms of an action (R: mm) um services if anything are more scarce now than they were when I started teaching” (Participant 6, 152)

Others expressed frustration with the lengthy, time-consuming administrative processes they are required to adhere to in order to access the additional support they believe pupils require:

“that’s the most frustrating part of being a teacher at times, it’s that when you can see that a child needs particular help, or that..a child’s struggling, it’s all the boxes and all the forms that a teacher has to go through, or all the phone calls or conversations to be able to get something done” (Participant 10, 651)

Participants noted that schools have also been adversely affected by funding cuts and consequently have a reduced capacity to offer additional, targeted support to pupils and families in need:

“because budgets have affected staffing levels in school, we’re now down to kind of minimal levels of teachers and teaching assistants which means that,

where we would have been able to kind of support the families in erm..in the past and kind of make sure we had this pot of money that any child could be in any club, all of that has been pulled back” (Participant 7, 93)

“these past couple of years or so the amount of adults within the primary school has decreased quite significantly in terms of teaching assistants and pastoral care roles and learning mentors and it’s..it’s that sort of side of it that’s been cut which then I feel that they were playing one of the key roles in sort of that, um, emotional health side of things” (Participant 10, 413)

The depletion in accessible, timely support from CAMHS, voluntary sector services, social care and pastoral roles in schools, as a result of funding cuts and higher rates of referral, suggests that the burden of mental health support may fall more heavily on teachers now than it did previously.

3.3 School’s place in society; teacher roles and responsibilities

3.3.1 Changing expectations imposed on teachers

This subtheme explores the expansion of roles and responsibilities in teaching. There is discussion about how the boundaries of the teaching role have loosened to encompass a wide range of initiatives and duties. The ways in which teachers contribute to the prevention of child mental health issues and their understanding of school based interventions are considered. Potential issues with incorporating the subject of mental health into the primary school curriculum are discussed. The impact of the role on teachers and the stresses and pressures on the profession are also thought about within this sub-theme.

Many of the participants made reference to dilemmas schools and teachers face around their place in society and the roles they may be required to hold in mental health prevention. All of the participants commented on the increasing breadth of teachers’ roles and responsibilities. Many spoke of how the boundaries of the role have expanded over time to encompass duties traditionally held by other professionals:

“I think it..it kind of has become more and more over the years I’ve been teaching as well, we’re a kind of jack of all trades and master of none and mental health is one of those” (Participant 2, 614)

“as a teacher nowadays you have to be a social worker, counsellor and psychologist..like a psychotherapist, and then a teacher” (Participant 4, 100)

“I kind of feel, in the context that we work in, that our teachers have to be like social workers..I mean lots of children comment that they’re like their mums and teachers rolled into one” (Participant 7, 109)

Several of the participants referred to frequent initiatives that teachers are required to be informed of and act upon, which indicates that schools are under pressure to share, or hold, responsibility for the prevention of a range of societal issues in addition to their primary role as educators:

“while every member of staff has to do safeguarding training, they have to think about..to pass the safeguarding test, we have, um, Prevent training which is the, um, the kind of, um, the terrorism training, we have..we’ve done some work with Stonewall, we’ve done some work with Country Lines which is kind of identifying, kind of, especially at the moment (R: uhuh) all of the drugs coming into the county” (Participant 11, 431)

“it felt at the time, I remember it being announced at the time..is this along the same lines as preventing knife crime” (Participant 2, 426)

“I mean, lots of yeah, lots of things around kind of..with gang prevention and mental health linked to that” (Participant 7, 111)

One participant described how teachers’ duties can extend to dealing with behaviour that occurs outside of school hours, with incidents that take place on social media infiltrating the school day. This is referred to as a ‘tricky position’, suggesting a discomfort with the lack of clarity in the boundaries and limitations of teachers’ responsibilities:

“we’re constantly having to deal with things that have erupted over night or over the weekend where children have gone on social media or a group chap

and the arguments are continuing on there and some of them are sort of quite, quite horrible things being sent and then as a school, it's a really tricky position because obviously it's not being done during school time but, erm, obviously at the same time it's effecting children within the school day so we're having to deal with it" (Participant 10, 111)

Another participant's response suggested that schools in areas with higher levels of deprivation, where the impact of austerity measures are more visible, are likely to perform tasks typically associated with social care:

"the school has always gone over and above to work with families; home visits, getting into the home to help with behaviour, um, helping family with kind of money worries and things like that..I think that's probably taken on roles of other erm services as well because..because, um, we felt that we needed to, in the past, because of the levels of deprivation and mental health" (Participant 7, 84)

There is an indication that high levels of deprivation and mental health issues may lead teachers to feel compelled to take on additional responsibilities, perhaps out of a sense of moral duty or concern that these needs would otherwise go unmet. There seems to be a dilemma around who would respond, if teachers did not.

All of the participants made reference to how there is insufficient time in the school day to address the multitude of duties they are expected to fulfil. Some questioned the realism of incorporating teaching on mental health into an already crowded curriculum. Responses indicated that mental health initiatives could be perceived as a burden; further additional responsibilities imposed upon teachers, without their existing high workloads taken into account:

"it's that important that actually it needs to be looked at that ok, well, this is what our expectations of what we want teachers now to be doing to prevent this, we realise this is actually going to come with more workload, so, so what can we now then do to sort of fit that in rather than another thing plonked on top of teachers, erm, for them to be looking out and for them to do on top of things like child protection, things like Prevent" (Participant 10, 301)

“the main issue is the time, and I know I keep saying it, I’d be surprised if other teachers hadn’t said it (laughs) but I’m just thinking about my day and what my weeks are like when I’m at school and, um, yeah I can easily do anything between 50 and 60 hours a week so it’s..it’s just, it might just be for some teachers just another thing that they’re then having to do” (Participant 10, 698)

In addition to the point raised that it is a big expectation to place on teachers, it was also implied that these initiatives may be delivered without due consideration of the resources and funding required to ensure efficacy:

“it is a massive expectation on top of all of the other expectations that teachers have day to day (R: hm mm)..so, you know it is absolutely important, but it has got to come with support, resources, funding and everything else it is going to require if it’s going to have an impact.” (Participant 1, 322)

As well as practical considerations, some responses suggested a conceptualisation of mental health as a complicated, difficult and daunting topic:

“at what point in my job would I be doing that, along with everything else I have to do? It would be um..that’s kind of a massive thing for teachers to take on” (Participant 8, 377)

“it’s kind of a big ask, from a teacher point of view, I would say, really..not that, you know, not that I wouldn’t act upon it but to do it daily would be quite..quite time consuming and yeah, it’s also a big, a big topic, a big..it’s quite wide isn’t it, it’s quite a big topic rather than quite a little thing” (Participant 8, 382)

The responses from this participant indicated a concern that they would be asked to do things outside of their training, skills and experience. These responses also implied a lack of confidence around the topic of mental health, which will be discussed in more detail later in this chapter.

Participant responses indicated that schools and educational professionals hold a range of skills and resources relevant to the prevention and management of child mental health issues. Many participants made reference to a feeling of responsibility and duty in supporting their pupils’ wellbeing. Creating a sense of safety, identifying

issues, preventing triggers, having open conversations about wellbeing and signposting and liaison with external agencies were all mentioned as important roles teachers hold in the prevention of child mental health issues:

“I spose if you’re thinking about relationships being possibly one of the most important markers of somebody’s um..mental health you know, I think you’re in a really, you’re in a really great place as teachers to be able to spot when things are going well for children and also when they’re not, in a way that maybe parents don’t see or, um, healthcare providers don’t see you know, you’re on the frontline so with that comes sort of a responsibility to check in” (Participant 6, 201)

“preventing triggers, looking at how we can, kind of, make sure that those 6 hours they have with us at school they’re in a safe environment, they feel safe coming to school, they feel that they can talk to somebody” (Participant 11, 459)

Differentiation was made between the higher level of support required by some pupils, who may benefit from external agency input, and a more general, whole-school approach focused on the school environment and building empathic relationships:

“noticing, reporting um..seeking support for families um and just being that kind of bridge I suppose, if it’s needed, between parenting and school um..sometimes social services and the police, it certainly could be the case, so I spose you have that side of it where the teachers’ role is really crucial, um, and then kind of probably a more general, um,..approach for the majority of children would be about creating an environment without prejudice um..where children are, um, encouraged to have empathy with others, where the teacher has empathy with them..possibly where there’s an open discussion about wellbeing and erm..that sort of dialogue is open” (Participant 6, 60)

Although all of the teachers identified some systemic causes of child mental health issues, the school based interventions they referred to were largely in line with individualistic conceptualisations of mental health. The concepts of ‘resilience’,

'empowerment' and 'mindfulness' were cited, indicating that primary school teachers are asked to teach children skills with which to manage their own distress:

"offering children more challenge and having more resilience has been quite a big thread through the curriculum in recent years" (Participant 2, 198)

"there is definitely more of a focus on mental health now um..we do lots more at school in terms of mindfulness and creative relaxation and giving children strategies for dealing with um..different stresses and strains in their lives" (Participant 1, 64)

"I think it's about empowering children in, you know, in...it's difficult when they're so young..but in, you know, in having an awareness about their own mental health and in wellbeing and what they can do" (Participant, 1, 243)

One teacher expressed their frustration with the focus on individual intervention rather than systemic prevention. They acknowledged the dilemma schools and teachers face, in trying to provide children with 'tools' with which to manage challenges and difficulties whilst having an awareness that broader changes are required in the wider systems and structures that interact with childhood and cause harm to children:

"it's frustrating to think that the solution is to teach children how to cope better with all these stresses and feelings and emotions rather than, well, how can we balance out their lives so that...you know, and that's not to say that children don't need to have those tools because, you know, they will encounter things that are difficult, they will encounter challenge, they will encounter emotions and feelings so they need the tool-belt to tackle a range of..a range of situations that..um, we could be doing so much more to get their childhood so they didn't have to be suffering through a lot of the things that children have to suffer through" (Participant 6, 352)

This same participant later expanded on these thoughts and expressed their view that broader system change is required, rather than asking teachers to deliver individualised approaches which position children as responsible for their own mental health:

“maybe let’s look at the system instead..um something needs to give, something needs to change in the way..it’s not just a teaching issue, what are we doing to our children to make them so anxious? Maybe instead of telling teachers to teach them about anxiety we should um..we should be reducing the pressures that make them anxious in the first place” (Participant 6, 563)

Some referred to education as being an act of prevention in itself, highlighting that by performing their traditional, educational responsibilities teachers make an important contribution to mental health prevention:

“I’ve seen with our children the more confident they feel as learners actually it does wonders for their mental health because their self-esteem comes up and their confidence comes up” (Participant 7, 300)

“in terms of, um, you know, education, you know as a teacher that is like your main role, but the more you can kind of put into that, erm, you know the older the children can get, can maybe be a bit of a like protective factor, you know if they have kind of, if they feel more skilled in certain areas, um, of their education” (Participant 9, 95)

However, as discussed earlier in this chapter, teachers are overburdened with tasks and responsibilities which can detract their time and attention from their key role of educator:

“I think the buck has to stop with us at some point because we..to put it bluntly if we had to fix the problems of potentially 30 children with mental health issues in our class, we would never, we would never be able to teach anything” (Participant 11, 472)

Participants’ responses conveyed the personal costs and stresses of the multitude of responsibilities and duties encompassed in the current teaching role. The pressures on teachers appear to have negative impacts not only on individual teacher’s wellbeing, but also the sustainability of the profession:

“I do really worry about the current state of, erm, the teaching career at the moment that, morale is really low and..and I work in a school where I feel that

actually morale is quite high, but we are sort of lucky, and then recognise that actually, as a profession there's quite a lot of people struggling and that's with workload, life balance" (Participant 10, 310)

The increasingly porous boundaries of the teaching role and the multitude of demands on teachers can result in their time being taken away from what they want to do and feel they should be doing. Teachers' dedication to pupils can lead them to over-work, missing their own breaks in order to address pupils' needs as they arise:

"I feel that lots of things that fall onto teachers um, because of the way that most teachers are, because they are caring, because they love teaching and they um obviously feel responsible for the children within their class that, um, that time is actually out of the teacher's own time (R: mm) erm and that actually, time isn't given within a school day to do it, um, just thinking about lots of issues and things that, um, arise throughout a school day, um, I deal with quite a lot of those during a break time or lunch time, erm, which is effectively, that should be my break time" (Participant 10, 398)

One participant's response indicated a working culture in which teachers feel under intense scrutiny, where they are held to unreasonably high standards with no room for error. They spoke of a fear of culpability around safeguarding issues and implied that the identification and management of pupil mental health issues could be perceived to hold the same gravity and expectation as safeguarding duties:

Researcher:...and what are your thoughts about what is expected of you and your colleagues in the mental health side of things?

Participant: "...I think a lot of expectation is placed on you and I think as well with the whole kind of safeguarding and child protection and I..I don't see this as like, i'm not saying that this is wrong, but I think because you're held accountable for their safeguarding and the protection of the children and if you're seen to, if it's discovered that you don't do something about something you knew you can lose your job, I think it's.. it's difficult you're almost like pressured,,and it's not like you wouldn't do it, because obviously you would do it cus they're children, but because you're held accountable for it it's..it's like a

three line whip, like you have to deal with all the issues that the children present because if you don't, then you could lose your job, you could get struck off. I remember when I was an NQT having my safeguarding training and you hear you can get hauled up in court if a child's being neglected and you knew something and didn't do anything about it, I remember feeling quite terrified about that.” (Participant 4, 209)

The references made to high workloads and various stressors indicate that the occupation places a strain on wellbeing. Teacher wellbeing was understood to be relevant and connected to the wellbeing of pupils and the importance of this link was noted by several participants:

“I think it's important to also look at the mental health of teachers (R: mm) cus if you want children to be, err, mentally, er, healthy and, and well, and obviously they need, they need the adults in that classroom that are also, erm, well, too” (Participant 10, 315)

“I think that helped us as teachers to feel more relaxed which means that the children were probably more relaxed” (Participant 3, 95)

Teachers' own poor wellbeing and mental health were portrayed as barriers to supporting pupil mental health, with the pressures and high expectations on teachers potentially acted out in the classroom, impacting negatively on pupils:

“mental health in all roles is a big thing I'm sure, but teachers are known as having very highly stressed lives (R: uh huh) and again, just the stresses and strains of everyday teaching, the other things that come with it can definitely be a barrier” (Participant 1, 230)

“teachers' own pressures being brought into the classroom.. if you are under pressure yourself, or under pressure you know, just generally under pressure, you're then anxious and that comes out in whatever you're doing..but if you're under pressure then to perform or achieve at a higher level, then obviously you're pushing those children from that and then you become anxious yourself so..” (Participant 3, 4)

The interview data conveyed a sense of dissatisfaction with the current Primary school educational system in the UK. In line with previous points raised, including issues with the curriculum, workload and role expectations, concern was expressed about the direction the teaching profession is heading in. The following quote suggests a fear that the pressures and burdens are unbearable, potentially pushing teachers to reach breaking point:

“I am concerned about the profession as a whole in terms of where it’s going and I think it is going to come to a point where it is going to break and then things will need to change in terms of, um, how the government, um, are leading on education” (Participant 10, 704)

3.3.2 Home and school; who holds responsibility?

Previously, this chapter has discussed how participants referred to the overlap between their roles and those of other professionals. In this subtheme, the overlap in tasks performed by teachers and caregivers is explored. The dilemmas teachers face when deciding how much to intervene and feelings of duty to children, families and broader society are discussed. The potential for tension between perspectives held by home and school is considered.

Many of the participants emphasised the special opportunities schools have to provide children with a safe and nurturing learning environment outside of the home. The pupil-teacher relationship was understood to be at the core of this safe base and a foundation of mental health prevention:

“I think schools have a huge responsibility to make sure that, um, they have a secure attachment to..with, class teachers have, to attachment to all the children and providing an environment where children are..um, able to learn without judgement, without um..criticism or with healthy criticism, or supportive feedback, that sort of stuff, um, I suppose it is the school’s responsibility to create a positive learning environment that also supports children’s individual needs and celebrates them as well” (Participant 6, 39)

Some participants spoke of providing structure and feelings of safety which can be absent from pupils’ homes. The following responses indicate that teachers may try

to compensate for what can be lacking in some pupil's chaotic lives outside of the classroom. These may not be actions which are recognised as part of a formal mental health prevention strategy and may be a taken for granted part of the primary school teacher role:

“so then at school, obviously, we’ve got to kind of deal with that, so at my school we try to create a very calm environment for the children so we have a staggered start to the day so the children can come in from 8:30 and we don’t take the registers til 9, so they can dribble in and it’s nice and calm so there’s no big rush...” (Participant 4, 24)

“for the children they need to..they come to school, they love school because it’s their safe place and they know what to expect at school. At home they don’t know what to expect” (Participant 4, 29)

As well as feeling under pressure to adopt roles traditionally held by a range of other professionals, several teachers spoke of performing parental tasks. Responses indicate that this occurs at the request of parents and also when teachers feel obliged to step in, possibly when parents are unable to support or provide for their children. In addition to the sense of responsibility teachers carry for their pupils, the descriptions alluded to the special nature of the pupil-teacher relationship which differs from the relationships children have with other professionals:

“you are also expected to be parent, you know, teach the children about manners..I’ve had to teach a four-year-old to eat a sandwich before, eat a yoghurt and drink out of a carton I mean, for me, that’s a parent job. The other day I had to sit down and talk to them about personal hygiene and washing and keeping your body clean, because a parent had said that their child was concerned that they were smelling” (Participant 4, 102)

“we make sure like greeting every single child, making sure we know if they’ve had breakfast, erm, making sure that they’ve got a full school uniform and if they haven’t, because things are going on at home, we put the tie on them so that they feel throughout the day they’re as loved and cared for as all the other families” (Participant 7, 494)

“if it helps the parents, then we would keep the child kind of after school for a slot to give them the kind of extra revision slash giving them dinner just all that kind of..I guess the role of the parent when the parent’s finding it really difficult”
(Participant 7, 498)

Some participants described the dilemma of being in a position where it feels difficult and potentially neglectful to not intervene when child wellbeing is at stake, even if this means acting outside of a standard teaching role:

“because they’re children..you’re not going to neglect a child are you and if you see that there is something they’re lacking that really should be provided by home but you can do that in school, you’re not going to not give it to them because like, fundamentally, you go into teaching because you want to help children and you want to help them become the best that they can be”
(Participant 4, 195)

Responses conveyed a sense of moral duty to children, families and broader society but implied that this level of commitment can take a toll on teachers:

“I think it’s incredibly taxing for..to teachers, erm, but I also feel quite strongly that we have a responsibility, erm, to these children to be there for them not just in an educational sense but as, you know, part of their whole development, their whole being” (Participant 6, 197)

The following participants described how teachers hold responsibility to address problems and prevent future escalation. There was a sense of a lack of confidence in some parents to respond effectively, leaving it down to teachers, as the first port of call on the frontline, to act:

“because some children literally..it’s school and home isn’t it..so if parents aren’t doing it, then perhaps teachers should be doing it..and if there’s no-one else..otherwise it just escalates and it gets worse the longer it goes on for doesn’t it” (Participant 5, 102)

“and if they’re not being provided it at home..we kind of do have to plug that gap because you don’t want to have to end up having generations of disengaged, you know a generation of the population that’s like emotionally detached and disengaged you know that..not gonna help is it” (Participant 4, 331)

Some responses implied a tension around what teachers feel obliged to provide for pupils. One participant expressed feelings of frustration about some of the parental delegation of responsibilities to teachers:

“we were kind of aghast that we had to do it, obviously we did it because it's for children’s wellbeing, we were just like, what a joke, no you can't pass the buck on to the school because you don't want to have a conversation with your children about keeping yourself clean, you know” (Participant 4, 108)

“there’s a bit of a cultural shift with parents as in, I don’t need to worry about that because school will fix it for me, and I found that I was having to deal with behavioural issues at home in school and you don’t mind as a teacher, parents coming to speak to you telling you they’re having issues with behaviour at home, do you have any tips and strategies I can do at home to help, and that’s fine cus you are sort of..a professional you know..but when you’re having to discipline or reward a child at school for their behaviour at home, that’s very different, so that’s quite..I’ve noticed that more and more and very much so now.” (Participant 4, 180)

This may indicate that some parents share teachers’ uncertainties about the boundaries of their role and how much responsibilities are shared between home and school. The reported increase in responsibilities resting on teachers, for example parents asking for and expecting teacher input on behaviour management at home, may reflect the aforementioned cuts to external agencies who would typically provide this form of support.

The same participant also spoke of their concern that intervening in typically parental responsibilities may not be effective in the longer term. There is an

implication that the situation runs deeper and cannot be addressed by teachers stepping in and filling gaps in the system. That instead, there needs to be consideration of the whole system and the support available to children and families outside of education:

“it’s fixing the issue but it’s not fixing the problem is it” (Participant 4, 199)

Despite performing parental duties, several participants commented on the limited impact of teachers in comparison to that of parents.

“you can do so much in the classroom but they’re only with you for a certain number of hours per day” (Participant 5, 199)

“I wouldn’t necessarily say that we can do a huge amount to prevent children’s mental health because we have them for 6 hours of the day the rest of the time they’re at home” (Participant 4, 64)

The following responses suggest a tension between the approaches used at home and school, with teachers’ efforts being seen to be ‘undone’ at home. There was some implication that parents may benefit from adopting teachers’ approaches to children’s issues and that children would benefit from this consistency:

“We can do as much as we can, but essentially a lot of the time I find that what we do in school is undone at home, so you’re constantly having to re-do the same things again and again and again.” (Participant 4, 68)

“when they go home that can all be undone and then they come back the following morning and actually..I mean lots of research says home has much more of an impact than school does so..you can’t teach the parents though can you” (Participant 5, 201)

“when obviously you’ve got the parents on side that helps so, I think, maybe in terms of preventing children’s mental health, it’s trying to get the parents on side so they’re doing at home what we’re doing at school” (Participant 4, 72)

One participant spoke of the complexity of broaching the subject of mental health with parents and the stigma that can be a barrier to these discussions:

“lots of our parents have got, there’s a lot of stigma around mental health and so if we try and approach the parents about the child in the class they will completely shut it down straight away” (Participant 7, 360)

They also commented on tensions around parents’ differing beliefs about the boundaries of a teacher’s role, which may differ from the expectations of the education system and make the role of the teacher more difficult:

“one parent has been so, so anti-talking about anything mental health about their child that actually they said to the teacher ‘your job is to teach my child lessons, not to think about their emotions’ and with that, that’s commonplace” (Participant 7, 364)

3.3.3 Expertise deficit

In this final subtheme, perceptions of a lack of skills and experience around mental health are discussed. An understanding of mental health as a specialist subject and concerns about the potential to cause unintentional harm are considered.

Many of the teachers discussed their self-perceived lack of expertise and the limited training they have received in relation to child mental health:

“I would imagine that most teachers would feel under-qualified in that area so any kind of training around looking for signs and symptoms, teaching children strategies, and knowing how and when to support and when to refer would be really useful” (Participant 1, 285)

Several responses indicated that although teachers are well placed to identify issues and have relevant conversations with children, schools have minimal capacity to provide specialist support:

“It’s difficult, because you know we are obviously key people in children’s lives so we should definitely have a role in it..but it’s not what we are trained to do” (Participant 1, 320)

“there are some cases where there is only sort of...the role of the teacher only does go so far and then, you know, in mainstream schools where you’ve got, you know, a lot of children in your class, um, and then obviously the curriculum kind of testing and everything like that, there’s all those demands” (Participant 9, 128)

There appeared to be a conceptualisation of mental health as a specialist subject that should be addressed by specially trained professionals. Some responses indicated a concern that teachers may be asked to perform tasks outside of their areas of competency:

“there must be people out there who are trained to do it rather than teachers who aren’t trained to do it necessarily they’re..I’m not, we’re not trained to be solely mental health you know, it would be, and for me I wouldn’t know the knowledge that trained mental health people would if that makes sense..so I don’t think that I would necessarily be the best person to do it, because of time and also for professional knowledge wouldn’t be up to scratch compared to other people who have got it completely up to scratch” (Participant 8, 397)

“we’re not trained psychologists, psychotherapists, counsellors..we’re not trained in that as a teacher, like..so there’s a limit to what we can provide in school” (Participant 4, 242)

There was some recognition of varying forms of mental health presentations which pointed to a consideration of what is common and manageable within a school environment and what might require specialist knowledge and support:

“you can have a conversation with children about how to handle your stress and relaxation and that’s not the same as children who are having a psychotic episode, necessarily..and I don’t..yeah..we’re not..we’re not trained mental health professionals..to deal with those kind of things and I think we still need to recognise that those things are..not the same.” (Participant 2, 451)

One teacher described how a self-awareness of skills and competencies was particularly important when working with children who have experienced significant trauma. The use of ‘horrific trauma’ in this statement highlights the levels of emotional distress and complexity that teachers encounter:

“well we’re working with children who..some of them have experienced horrific trauma, lots of domestic violence, abuse, er, and lots of our teachers are very honest about the fact that they don’t know what to do for the best and I think..I think that is very good in itself” (Participant 7, 235)

They also touched on the potential for well-intentioned intervention to be misguided and unhelpful. Although it may seem a positive idea for teachers to have a range of intervention options available to them, this participant highlighted the need for adequate training and consistent delivery to ensure interventions are meaningful and avoid exacerbating difficulties:

“I mean there’s, there’s textbooks on cognitive behavioural therapy and lots of things like that and actually lots of teachers could pick up and say ok, I’ve got this child in my class, we’re gonna do this for 6 weeks, or like Lego therapy we’re gonna do this for 3 weeks and then never again, you know it’s..or that you put things in place like brain breaks or things like that and actually in that brain break the child is doing something that is completely not helpful so it’s just, it..anything like this where the children have experienced some of the most harmful things, have to be so carefully thought through” (Participant 7, 239)

Importantly, in addition to the recognition of a lack of specialist knowledge around child mental health, some teachers expressed a fear that they could cause unintentional harm to pupils as a result of intervening without specialist skills and training. When asked their view on teachers being given materials to provide mental health education for all primary school pupils, as suggested in the 2019 Mental Health Prevention Plan, several spoke of a sense of risk and danger:

“I think confidence is a big thing, thinking you know, am I going to, are my actions going to support this child, or damage this child” (Participant 11, 546)

“it’s kind of such a specialist area that if you get it wrong, you could be doing lots of damage um and you could..yeah it needs to be delivered by somebody who really knows what they’re talking about and who has lots of experience and it would have to be really carefully thought through and not just kind of another initiative..” (Participant 7, 222)

“perhaps we could deliver it if we had sufficient training, but there’s a danger I think of it being a bit slap-dash or a bit have-a-go..erm..(R:mm) which, you know, could potentially be really dangerous” (Participant 2, 618)

Responses conveyed the dilemmas teachers face. The following participant indicated a sense of responsibility for the identification and prevention of mental health issues, whilst also being wary of not causing unnecessary anxiety to children who do not require additional support. There was a sense of wariness; of not fulfilling professional obligations or risking complaints from parents:

“I don’t know how I feel about that because if you..if you don’t do it from day one, don’t catch them early and there are problems..you’ve not done your job, but if you’ve got a child from quite a happy home..like my own child, I’m not too sure how happy I’d be that the teachers were talking about things like that (R: mm) it’s really..it’s really hard isn’t it, it’s really..but if there were children on the other side of the coin that needed it, that’s important as well” (Participant 5, 132)

Several teachers referred to mental health as a subject area to be approached with caution and sensitivity. They expressed concern that broaching the topic could potentially open up difficult conversations, in which they may lack confidence in how best to respond to pupils. There was some concern that a focus on mental health in schools could exacerbate issues and have unpredictable, harmful consequences:

“it’s a sensitive area I suppose, or it can be (R: mm) also I think, you know, you can deliver it and you can teach it but you don’t know what the pupils are going to come back with and what it’s going to open up, and then you’ve got to feel not only confident in delivering materials but also kind of responding in an appropriate way” (Participant 9, 416)

Some responses also suggested a binary view of mental health problems, in that children either have them or they don’t, with children potentially singled out and labelled:

”and then is it gonna single children out? Cus already, I’m thinking like..my own child knows which reading level they’re on, and can tell you which reading level other people are on..now if they can do that for other reading levels I’m pretty

sure they could do that for..you know, they could pick other children out” (Participant 5, 126)

“I mean you don’t want to label a child with anything you know, you don’t want to say ‘well they’ve got mental health issues’ if they haven’t” (Participant 3, 162)

One participant expressed uncertainty about the appropriateness of younger children being taught about mental health. Their response suggested a view of younger children as being exempt from emotional distress. Their response conveyed a teacher’s role in protecting children from harm and seemed to express a belief that young children should be protected from a difficult subject and a potential ‘lost innocence’:

“do they need to know that some children struggle with mental health, then yes they do but..not necessarily when they’re 4 and 5..I think..I think, if they can, it’s nice just to not have any worries and any cares..in reception and key stage 1 you know..ok later on but really, when they’re young, maybe I’ve got an idealistic view of the world..and..you just don’t want to expose them to things that you don’t have to” (Participant 5, 143)

In addition to skills and professional experience, teachers’ lived experiences of mental health issues and how these interact with the societal stigma associated with mental health issues may be a barrier to teachers feeling capable of having conversations about mental health with pupils:

“we can see it happening but knowing what to do, really..probably that lack of awareness and understanding..and I think that’s society in general I don’t think that is..I don’t think that’s just teachers, I think you know..it’s something you don’t talk about isn’t it, still, it’s a little bit...mental health issues are something you don’t talk about and probably wouldn’t... especially as you might have mental health issues yourself or in your family..so you know, you might have that stigma within you..” (Participant 3, 270)

4. DISCUSSION

4.1 Overview

This chapter provides a summary of the key research findings, which are considered in relation to the research questions and the existing relevant literature. Following this, a critical evaluation is presented and the potential implications of the research for clinical psychology are considered.

4.2 Findings

4.2.1 Summary of Findings

This study aimed to explore primary school teachers' perspectives on their role in the prevention of child mental health issues. The research sought to gain a better understanding of the following research questions:

- What are primary school teachers' views on the roles they are being asked to perform in the prevention of mental health issues in pupils?
- What helps primary school teachers in their role in the prevention of mental health issues in pupils?
- What hinders primary school teachers in their role in the prevention of mental health issues in pupil?

The results of the research depict the complex position teachers are in on the education frontline, where they bear witness to the daily lives of children and families. The findings indicate that participants view child mental health issues as occurring within a context of a multitude of societal and systemic stressors and disadvantages including poverty, family conflict and academic attainment pressures. Whilst participants have observed an escalation in these needs and issues they have simultaneously experienced increasing difficulty in accessing specialist support for pupils. Dilemmas, frustrations and tensions were expressed, with many commenting on their ability to identify when children might benefit from additional support but feeling they lack the necessary time, skills, training and resources to intervene. There appeared to be a lack of clarity around where the

boundaries of a teacher's role in child mental health prevention begin and end and what a preventative approach might look like. Similarly, participants appeared to lack confidence and clarity as to the threshold for what constitutes a child mental health issue and how this may diverge from typical childhood difficulty or a concern of a safeguarding nature.

The interaction between the current primary school education system and child mental health was discussed and some participants shared their observation of the harm the restrictive curriculum and extensive assessment processes can cause to children, resulting in them being overloaded and having limited opportunities for play, creativity, exploration and reflection. The education system also was viewed as having a negative impact on the wellbeing of teachers and the link between pupil and teacher wellbeing was highlighted. Participants emphasised the breadth of their workload and the high expectations imposed upon teachers and some questioned the feasibility of incorporating mental health related responsibilities into their role. There was some concern about the implications of delivering teaching on the topic of mental health in primary schools, as suggested in the 2019 Mental Health Prevention Plan, with the subject portrayed as somewhat difficult and daunting.

Despite raising issues with the education system, participants also noted the value of school as a safe environment for children. The significance of the teacher-child relationship was emphasised and this relationship appeared to be an important foundation in the prevention of child mental health issues. Participants expressed their sense of duty to children, families and broader society and how this can lead them to work beyond the, albeit unclear, remit and limitations of their role.

These findings will now be considered further in relation to relevant literature.

4.2.2 A teacher's role in society

Some of the key findings of this study relate to conceptualisations of teachers' roles in society. Participants expressed the dilemmas they face when deciding to what extent they should intervene in the lives of children and families, particularly when they witness significant needs going unmet and children falling through cracks in the system. Participants depicted the special nature of the teaching role and an awareness that their position on the frontline allows greater insight into the everyday experiences of children than is available to many other professionals. This unique

position appears to entail a sense of moral obligation and duty to children, families and broader society.

These findings support those of Kidger et al's 2010 research in UK secondary schools, that teaching and child wellbeing are inevitably linked. There was an acknowledgement of areas where the multi-faceted teaching role has begun to overlap with that of social workers and mental health professionals and, as in previous research, some discomfort and frustration about the implications of this for teachers, including an encroachment on their pedagogic role (Rothi et al., 2008). Over the past decade, since these previous studies were carried out, cuts to public services have resulted in teachers and schools filling the gaps in resource. The current study's participants conveyed a sense of fear that not intervening by filling these resource gaps may result in problems escalating into longer term issues, beyond the classroom and childhood. This depicted the complex position teachers are in, having to assess for themselves the risk of not intervening versus the consequences of fulfilling roles and responsibilities conventionally held by others.

In some previous studies teachers have expressed an acceptance that the rise in mental health difficulties among children and young people requires a change in school practices (Kidger et al., 2010; Rothi., et al, 2008). However, Shelemy et al's 2019 secondary school teacher focus groups referred to the societal expectation that teachers have a responsibility for the wellbeing of their students and contested this notion, arguing that their role should be purely educational. In the present study, the findings did not indicate a clear stance around what participants believe the limitations of a teacher's role should be and instead highlighted the ethical and practical dilemmas teachers face when confronted with issues related to child mental health and wellbeing. Notably, all three of the research studies referred to above were conducted with secondary school teachers who may hold a different perspective to those working in primary schools, where teachers remain with the same class for a full year and the pastoral care element of the role may be more embedded and hold greater prominence.

One of the consequences of taking on additional, non-teaching roles and responsibilities is an increase in teacher workload. High workloads are amid the

stressors that appear to place a strain on the wellbeing of teachers (Education Support Partnership, 2019) and this was understood by some participants to have an impact on pupils, with poor teacher wellbeing found to be a barrier to supporting the mental health of pupils. This lends some support to previous research, which has indicated that teachers' own emotional health needs are neglected, leaving them struggling to consider those of their students (Rothi et al., 2008; Kidger et al., 2010)

The findings of this study depict how the lack of clarity in the boundaries of a teacher's role is evident in interactions with parents and caregivers and the way in which primary school teachers perform roles traditionally held by families. In some instances, parents have requested that teachers address their child's issue, in others teachers have observed an unmet need and intervened and, in some cases, parents have rejected this intervention. Some participants described tensions they have experienced when discussing mental health concerns with parents and indicated that some parents do not view this as part of a teacher's role. Family relationships and socio-economic status were among the factors which participants highlighted as having an impact on child mental health. The findings support previous research, which has emphasised the important role of school in society, in providing a safe, supportive place for all children (Danby and Hamilton, 2016). It appears that the conceptualisation of school as a safe place and efforts made to create a calm and empathic environment may be an attempt to compensate for some of the chaos, disruption and disadvantage in children's home lives. However, despite making these efforts, some participants expressed a sense of futility in their role in the prevention of mental health issues, where families are understood to have a greater influence on children's wellbeing.

The current Covid-19 pandemic and the heated discourse surrounding the proposed reopening of schools highlights both the importance of teachers for society and the ways in which the parameters of their role are contested. Some have opposed the re-opening of primary schools, citing health concerns for teachers working in an environment where it will be especially challenging to enforce social distancing and arguing that teachers are being made to feel expendable. Simultaneously, there has been concern expressed about the risks of ongoing school closures to children's

mental health and the safety of vulnerable children (Hudson, 2020) with the Children's Commissioner stating that many of those who are disadvantaged are being put at further disadvantage (Coughlan, 2020). Schools have been asked to remain open throughout the crisis for the attendance of vulnerable children and children of keyworkers, which demonstrates the vital role teachers are understood to play in keeping children safe and making it possible for society to continue to function. However, it could be argued that teachers are being positioned as economical childcare rather than educators and schools as safety nets rather than educational environments. The requirement for schools to remain open for vulnerable children and the safeguarding concerns for disadvantaged children amidst school closures echoes sentiments raised in the current research findings, that school is viewed as a safe place and teachers are perceived as playing an important role in addressing social inequalities.

4.2.3 Mental health prevention in primary schools

The study's findings demonstrate varied understandings as to what constitutes a child mental health problem and how this can be distinguished from typical emotional and psychological experiences in childhood. The findings resonate with those of Harrap (2016) whose participants pointed out the vague nature of the term 'mental health' and voiced uncertainty about how to distinguish child mental health issues from usual experiences. This also echoes debates within the field of clinical psychology, with a lack of consensus of definitions and where a boundary between health and illness may lie, including concerns about the medicalisation of human experience (Horowitz and Wakefield, 2007; Scott, 2010). The references made to safeguarding, in response to interview questions about mental health prevention, demonstrate the overlapping, interwoven nature of mental health, wellbeing and family context. It perhaps also denotes a perception of child mental health as involving risk that requires involvement from external agencies.

Approaches to mental health prevention appear to differ across schools and there did not seem to be a common consensus of how mental health prevention in primary schools is structured. As discussed in this thesis' introduction, concepts such as resilience appear to be prominent in preventative interventions aimed at children

and young people. When asked about prevention in primary schools, participants spoke about strategies with a focus on resilience, mindfulness and empowerment of pupils. This suggests a conceptualisation of mental health prevention as being focused on individual management strategies, which seems at odds with participants' knowledge of the impact of deprivation and social disadvantage on the mental health of children. The results indicate that there are some tensions between the teachers' knowledge of broader causes of child mental health issues and their understandings of possible preventative intervention, with minimal references made to whole-school approaches or community and structural levels of prevention which aim to address social, economic and environmental causes of distress. The teacher's responses indicate that, despite their awareness of the role of structural inequalities, they are working within a system that is failing to address these issues and where their professional values and beliefs about what is beneficial to child wellbeing may be in conflict with what they are asked to do within their role.

The aforementioned creation of a safe environment, where empathic relationships between teachers and pupils are encouraged, appears to be an important foundation of prevention in schools and perhaps one that is taken for granted and not always recognised as preventative action. However, the demands of the curriculum and workload can make it difficult for teachers to dedicate time to this crucial, relational aspect of the role. Participants highlighted the multitude of stresses and pressures that children are subject to inside and outside of school. Although, as previously discussed, school is considered a safe place there was also mention of harm caused by the current educational system and its primary curriculum. Some participants expressed frustration with the suggestion from recent policies that teachers should deliver mental health education (DfE, 2018; Gov.uk; 2019) and suggested it would be more effective to focus on systemic causes of distress within the education system. This raises the question as to whether the difficulties we are witnessing in children and young people are mental health issues or, in fact, an understandable, ordinary response to the stressful environments and pressures they are subjected to.

Similar to previous UK research findings, participants expressed a desire for further training to support them in the identification of mental health issues in pupils (Rothi

et al., 2008; Annafreud.org, 2017; Shelemy et al., 2019a). There were questions raised about the feasibility of incorporating meaningful mental health education into an already over-crowded curriculum and the need for further training to deliver this effectively. There was a sense that teacher's knowledge and expertise, in education and the learning and development of children, are not valued by a system which allows them limited autonomy in what and how they teach. Yet this same system expects them to adapt and perform tasks beyond their existing skills and training, including the provision of teaching on mental health and offering mental health related support to pupils. With a decrease in funding and over-stretched specialist resources it has become increasingly difficult for teachers to support primary school pupils, as has been found in previous studies (Danby and Hamilton, 2016). The widening parameters of the curriculum and the scarcity of adequate health and social care provision indicate a system that is setting teachers and children up to fail.

The findings support concerns raised by teachers in previous studies about talking with children and young people on the subject of mental health (Cooke et al., 2016; Danby and Hamilton, 2016; Shelemy et al., 2019a). Some participants feared this could be detrimental to child wellbeing, with a risk of raising anxieties and pathologising children, and that primary school pupils may be too young to learn about mental health. This again raises the question of what constitutes mental health and which aspects of this might we be afraid of children hearing and talking about. There appears to be some discordance between the awareness of the reality of children's lives, in which they inevitably experience and are exposed to distress, and the perception of children as vulnerable and needing to be protected from exposure to distress.

4.3 Critical Evaluation

This research study was evaluated by drawing on Spencer and Ritchie's (2012) quality framework, which applies the principles of contribution, credibility, rigour and reflexivity to research evaluation.

4.3.1 Contribution

Contribution refers to the relevance of the research to theory, policy and practice (Spencer & Ritchie, 2012). Through the use of a qualitative approach, this study has contributed to the understanding of how teachers perceive their role in the prevention of child mental health issues. The existing literature on the topic gives limited attention to UK primary school teachers' views on the roles they perform in relation to child mental health. Several implications of the research findings, drawn from the participants' perspectives, will be suggested later in this chapter.

4.3.2 Credibility

Credibility refers to the plausibility of the claims the research presents (Spencer & Ritchie, 2012). In order to demonstrate the credibility of this study I have grounded the analysis in substantial, relevant interview extracts and linked the findings to relevant research. To support the integrity of analytic interpretations, I shared interview extracts and examples of initial coding and theme development with my thesis supervisor, which helped to strengthen the analysis and enhanced the credibility of the research.

4.3.3 Rigour

Spencer and Ritchie (2012) suggest rigour of qualitative research can be considered through consideration of the concepts of audibility, defensibility and reflexivity.

4.3.3.1 *Audibility*: Audibility refers to the documentation of decision making throughout each stage of the research process. In chapter two, I have documented my methodology and the stages of data analysis. To ensure transparency, I have included extracts of raw data (Appendix A) and data maps which illustrate the development of themes (Appendix B)

4.3.3.2 *Defensibility*: To support the rigour of the research, I have provided a rationale for the study and sampling and methodology decisions in Chapter two.

4.3.3.3 *Reflexivity*: Reflexivity involves an awareness of how my sociocultural position, beliefs, values and assumptions may have influenced the research process (Willig, 2013).

4.3.4 Personal Reflexivity

Throughout the research process I considered the potential impact of my dual position of clinical psychologist and researcher. I was aware that some teachers may consider clinical psychologists as holding expertise in the field of mental health and therefore might be concerned about giving 'wrong' answers to interview questions, or anticipate that I would assess or judge their approach. I was aware that teachers are subjected to regular scrutiny, in the form of observations and accountability measures, and wondered whether my interview questions could be perceived to contribute to the sense of being under scrutiny. I tried to reassure all participants that the research aimed to hear their thoughts and experiences as teachers, rather than looking for right or wrong answers. While attempts were made to put participants at ease, participants' varying levels of comfort and confidence in talking about child mental health with a mental health professional may have implications for the data obtained.

As mentioned in the results and summary of findings, some participants spoke about safeguarding issues in response to questions about mental health prevention. In addition to this representing, perhaps, the lack of clarity as to what is defined as a child mental health issue, I wondered if it might also signify a lack of confidence around the topic of mental health prevention. When I prompted participants to expand on their responses in relation to prevention, it seemed that some were unsure about this particular term. I was mindful of the need to clarify my questions and gather data relevant to teachers' roles in prevention but I was also aware of the potential distress for participants if I were to push them to expand on a concept outside of their familiar terminology or experience. I was struck by the difference between the individualistic examples of prevention and the references made to social and relational causes of mental distress, but struggled to reflect on this during the interviews and explore this further with participants. I was also aware that I came to the research with my own opinions and experiences of child mental health prevention, as occurring at multiple levels, and I may have assumed that these frameworks of understanding were common across professional disciplines. In hindsight, perhaps the interview schedule could have been adapted to include more

exploration of participants' understandings of the concept of mental health prevention before discussing how prevention takes place in schools.

Working in CAMHS before and throughout the research process, I had heard teachers express frustration and exasperation with CAMHS and the responses to referrals. I noticed that rarely participants expressed these sentiments and wondered how possible it felt to talk about CAMHS issues or complaints and whether some participants may have felt inhibited from doing so when being interviewed by a clinical psychologist with a CAMHS background, which the majority of participants were aware of.

The research interviews predominantly took place during the school summer holidays. I was conscious that teachers have limited time to themselves during term time and I was appreciative of participants' generosity in giving their free time to be interviewed. I felt some discomfort about encroaching upon their break with questions related to their work and was mindful of not over-running the 40-60 minute interview length detailed in the participant information sheet. At times, these concerns may have limited my inquiry and curiosity in the interviews.

Having numerous friends who are teachers and having previously worked in schools, I was mindful of my own assumptions and experiences and how these may have influenced the research. Through my social and work connections I have witnessed teachers being overloaded and overburdened and, as I analysed the data, I found myself paying particular attention to narratives that supported this perspective. I was also aware of how my clinical experiences and beliefs about the prevention of child mental health issues impacted upon the interviews and my interpretation of the research data. I noticed myself attending more often to narratives that situated child mental health issues within a social and systemic context as well as those that drew on ideas of attachment. I may have been more inclined to encourage participants to expand their answers where these ideas were articulated and may, therefore, have missed opportunities to further explore alternative narratives. When analysing the data, I re-read the transcripts and consulted with my research supervisor to help me consider alternative perspectives.

4.3.5 Epistemological and Methodological Reflexivity

Epistemological and methodological reflexivity encourages reflection on the strengths and limitations of adopting particular positions in research (Spencer and Ritchie, 2012).

Adopting a critical realist epistemological position supported the answering of the research questions by facilitating an exploration of participants' experiences and how these experiences interact with the material context they are working in. Alternatively, a social constructionist position would have allowed opportunity to consider participants' constructions of patterns of meaning in relation to wider discourses and ideologies.

Taking a critical realist position, I recognise that no single interpretation of the data can be considered the only appropriate version. There are likely to be a diverse range of potential interpretations of the research data and my own interpretations have been influenced by my experiences, views and assumptions. A further limitation of a thematic analysis approach is that it does not allow the researcher to make claims about language use (Braun and Clarke, 2006), which could have provided further insight into participant's views, understandings and motivations.

The methodological approach taken provided some opportunities and involved some limitations. The use of individual interviews allowed, perhaps, a space in which participants could voice more personal feelings of anxiety or self-perceived incompetency which may have been difficult to do in a group setting. However, the nature of an individual interview could be seen to enhance the sense of being assessed or under scrutiny. A focus group may have facilitated a richer understanding of the teachers' shared experiences and created a more comfortable environment in which to share their views. Alternatively, a mixed method approach with an option of anonymous written answers may have yielded different responses. The study involved a combination of face to face and telephone interviews. During telephone interviews I found it more challenging to encourage participants to expand on their responses, which may have limited the depth of inquiry at times. I was also aware that silences on the telephone may be uncomfortable for participants, and myself, and perhaps did not allow space for these as much as I would in a face to

face interview. Without the use of facial expression, eye contact and body language to demonstrate that I was listening, it felt more necessary to make listening sounds which may have interrupted flow of thought or implied agreement.

I am aware that my approach to recruitment may also have had an impact on the data collated. I contacted teachers I had existing relationships with and asked if they were willing to be interviewed and share information about the research with colleagues, who then shared their contact details with me if they were interested in participating. This may have biased the research towards teachers who have an interest and motivation to engage in issues related to child mental health prevention and, therefore, may offer limited insight into the views of teachers who are more reluctant, wary or critical of mental health related aspects of their role.

Detailed demographic information about participants and contextual information about their work environments was not gathered. This decision was made to maintain the anonymity of participants, with the hope that the teachers would be able to speak more explicitly about their interactions with schools, pupils, parents and the education system with the assurance that they or their school would not be identifiable. However, this does mean that the data is presented with minimal contextual information which limits consideration of the social, environmental and structural factors known to be relevant to child mental health and preventative interventions. Including data such as Ofsted ratings, rates of economic deprivation in the school catchment area or the percentage of pupils eligible for free school meals, as a proxy measure of socio-economic disadvantage, may have added useful context to some of the issues raised.

In terms of available participant demographics, the gender split of participants, 9 female and 2 male, is representative of the gender split in UK primary teaching where only 15% of primary school teachers are male (gov.uk, 2020). The research participants were all from White British and Irish ethnic backgrounds which means that the research neglects to include the views of teachers from Black, Asian and Minority Ethnic backgrounds. With the predominance of teachers in UK primary schools being White British, making up close to 89% of the workforce (gov.uk, 2020), a more targeted approach to sampling would have been required to ensure the ethnicity of participants was representative of the profession. All of the participants had significant teaching experience, ranging from 8 to 40 years and an

average of 14 years post-qualification. While this provided a wealth of experience and insight, it would have been interesting also to hear the views of more recently qualified teachers who may have had different interactions with mental health prevention in their training and career thus far. Participants worked in schools across a range of geographical areas but were predominately based in the south of England, with 9 of the 11 teachers based in London and the Home Counties. This geographical bias may have implications for the data gathered, with differing levels of disadvantage and variable resource in schools, Local Authorities and CAMHS across the country.

4.4 Implications of research

4.4.1 Study aims

The study aimed to further understanding of primary school teachers' views on the roles they are asked to fulfil in child mental health prevention and the opportunities and barriers they face in this role.

The results suggest that there are opportunities for teachers in their role on the front line to build empathic, supportive relationships with pupils, identify those who may be struggling and seek out appropriate support. The importance of education as a form of prevention in itself was also highlighted, with educational competence seen to benefit children's confidence and self-esteem.

As previously discussed, the findings indicate that teachers hold a complex position in relation to the prevention of child mental health issues and the nature and boundaries of their role lack clarity. Participants' responses indicate that there are numerous barriers to the relational and educational aspects of the primary school teacher role. These barriers include: a lack of time for individual conversations with pupils; an over-crowded, rigid curriculum; high workloads and a lack of internal and external resource for children in need of additional support. Further barriers include a lack of training on the subject of child mental health and prevention and a lack of confidence on the subject. Several of the teachers commented on a fear of causing harm or instigating parental complaints as barriers to conversations with children about mental health.

Clinical practice, policy and research implications are discussed below. This includes suggestions for how teachers can be supported to navigate the aforementioned barriers and contribute to child mental health prevention within their role in addition to a broader review of policy with the aim of addressing issues within the education and social care system including curriculum, workload and resource issues.

4.4.2 Clinical practice implications

The importance of supportive relationships and school being a safe place for children was highlighted in the research findings. In order for teachers to provide emotional containment to pupils and families, they too need to feel emotionally supported and contained themselves, as has been found with other professional disciplines (Menzies-Lyth, 1988). There may be a role for clinical and educational psychology, particularly for CAMHS clinicians working in schools, in providing teachers with a reflective space in which they can explore the emotional impact of their work. By attending to anxiety and distress in the system, teaching staff may feel better equipped to respond to the emotional and relational needs of their pupils.

The research findings indicate a lack of confidence in how best to identify and respond to children presenting with mental health issues and a desire for further training on the subject of mental health. The prevalence of mental health issues in UK school pupils has become an even more pertinent issues as a consequence of the Covid-19 pandemic and its broad reaching implications for families and society as a whole. There is an anticipation that rates of anxiety, school refusal and bereavement related issues will increase in children and families. Families who were already disadvantaged prior to the pandemic are anticipated to be at further disadvantage, with rates of abuse, domestic violence, unemployment and poverty expected to have increased during lockdown. Teachers feeling well equipped and supported to identify and respond to children in distress is of particular relevance when working on the frontline in this ongoing crisis and its aftermath. Again, there may be a role for clinical psychology in providing training and consultation in this area. In line with the uncertainties raised by participants, it could be helpful for this training to include opportunities to think about how to respond to children in distress,

in a manner that strikes a balance between empathising and containing concerns without adopting the role of therapist. With the lack of clarity and consensus around what constitutes a mental health issue, an online tool could assist in decision making around if and when to refer a child to external agencies. This type of online tool could, for example, provide information about what might be typical behaviours in a child following a bereavement and suggest when specialist or additional support may be required. Being mindful of the limited time teachers have to access further training, concise summaries and accessible, trusted online resources should be made available to minimise any additional administrative burden on teachers

4.4.3 Policy implications

In addition to possibilities for development within clinical practice, it is crucial to address the social and political structures which inhibit teachers from being able to apply their expertise in learning and development and be emotionally available to their pupils.

One aspect of school being a safe environment, for staff and pupils, involves all parts of the school system having clarity and coherence of roles and responsibilities. For teachers to protect their own wellbeing, they need to feel confident in the scope and limitations of their role. The research findings depict the vast breadth of a primary school teacher's role and the extent to which this can overlap with the duties of other professionals and, at times, parents. For teachers to set boundaries around their work, they need assurance from broader systems and government that children's needs can and will be met elsewhere. Without adequate health and social care provision, that is accessible to all children and families in need, teachers will likely continue to find it necessary to provide additional support out of a sense of duty to pupils and society and a fear of children coming to harm.

Many of the participants referred to the task orientated focus of the school day and the lack of time they have available to spend with individual pupils. The restrictive nature of the current curriculum and the emphasis on assessment and standardised markers of progress leave limited opportunities for play, nurture and creativity in

education. This suggests a broader review of the primary national curriculum, teacher workload and educational priorities is required.

4.4.4 Implications for further research

Several participants mentioned the important role of learning mentors in relation to the prevention and management of child mental health issues. Further research could explore the roles learning mentors and teaching assistants play in the prevention of child mental health issues and consider how this may differ from or complement the role of teachers.

The current research highlighted how the boundaries between home and school responsibilities are sometimes blurred. Further research with parents of primary school pupils could be of interest, gaining insight into their perspectives, experiences and expectations of primary school teachers in relation to the mental health of their children.

Another area for further research could feature the views of primary school aged children themselves. The importance of including children in research and hearing their perspectives on matters which concern them is gaining momentum (Mason and Danby, 2011). It would be valuable to explore what primary school pupils understand as a teacher's role in relation to mental health and emotional wellbeing.

4.5 Conclusion

To summarise, this thesis sought to explore primary school teachers' views of their role in the prevention of child mental health issues. Existing literature on the topic highlighted a lack of teacher confidence in the identification and management of child mental health issues, a lack of clarity around role boundaries, a desire for further training and some concern that talking about mental health with children could be inappropriate or harmful, all of which the findings of this thesis support.

The analysis of this thesis' data illuminates findings that are relevant to the professions of clinical and educational psychology and contribute to existing

knowledge on the subject. The findings demonstrate the complex, and at times frustrating, position primary school teachers hold in which they can recognise that children benefit from safe, supportive relationships and opportunities to talk, but are inhibited from consistently providing these due to the restrictive curriculum and attainment pressures of the current UK education system. The findings raise the question as to whether relational and educational aspects of a teacher's role, which they are equipped to provide and are conducive to mental health prevention, may be taken for granted and diverted from with a stream of new and ever-evolving initiatives. With concerns that the staffing issues apparent in secondary schools may become more evident in primary settings and increased rates of school related distress in children, further consideration of the pressures, demands and workload of the current education system is required.

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APPENDICES

Appendix A: Example transcript

Participant 10 Ts Can see/witness what contributes to CMH issues but lack training/skills/support - or not their role? - to address.

Importance of parent-teacher relationship

Parents as challenge/obstacle

Pressures on parents to work? Don't have familiar free relationships!

Nothing obvious

Experts have the answers, but don't. Acknowledged/inevitable to touch topic - should it be broached at school?

Teachers end up supporting parents/providing parenting support for parents of supporting child. What are external agencies is this? Lots of issues encroaching on Ts

Challenges

Parents

Different extremes - absent or over-bearing

Hard to build relationship

C issues result of parents' issues

Peer support

Ts discuss but had to approach parents - role of health prof./expert

Ts make suggestions to parents - communicating; simple?

P MH affecting C MH - Ps not getting support why not? Resources?

Minimising own knowledge & experience

anticipating judgment?

role of broader systems/relationships - outside of school but inevitably becomes inside of school.

Systemic/Family/external factors

Lack of support for parents has an impact on C

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440 primary school teachers when trying to work

441 preventatively around mental health?

442 P: um I'm trying to think um... I think um working with

443 parents can be quite challenging (R: hmmm mm) um

444 especially with um you get sort of different extremes of

445 parents in terms of, some parents you hardly see at all

446 because they are working before and after school so if

447 somebody else collects the child or they're walking home

448 by themselves, so it's really hard to build up that sort of

449 relationship with the parent um when you're not seeing

450 them on a regular basis um but then you have some

451 parents that sort of are quite over-bearing and as a

452 teacher you can sort of see that perhaps, maybe the

453 issues that the child's having is actually coming from the

454 parent um but obviously not being a health sort of

455 professional expert myself that's something that even

456 though as teachers we might discuss amongst ourselves,

457 that's quite hard to sort of engage in a conversation with

458 a parent about um you could do it in simple ways in terms

459 of suggesting things that perhaps you could do differently

460 with their child at home, perhaps maybe rephrasing

461 things in terms of how maybe, positive thoughts for

462 children rather than focusing on the negative, but I do

463 wonder whether is... is it a case of... is it the parents' mental

464 health um actually then affecting children's mental health

465 too, is it are they getting the right support as well um in

466 terms of their own mental health um and is that having a

467 consequence on maybe children's mental health but

468 that's me thinking about... um sort of from my tiny sort of

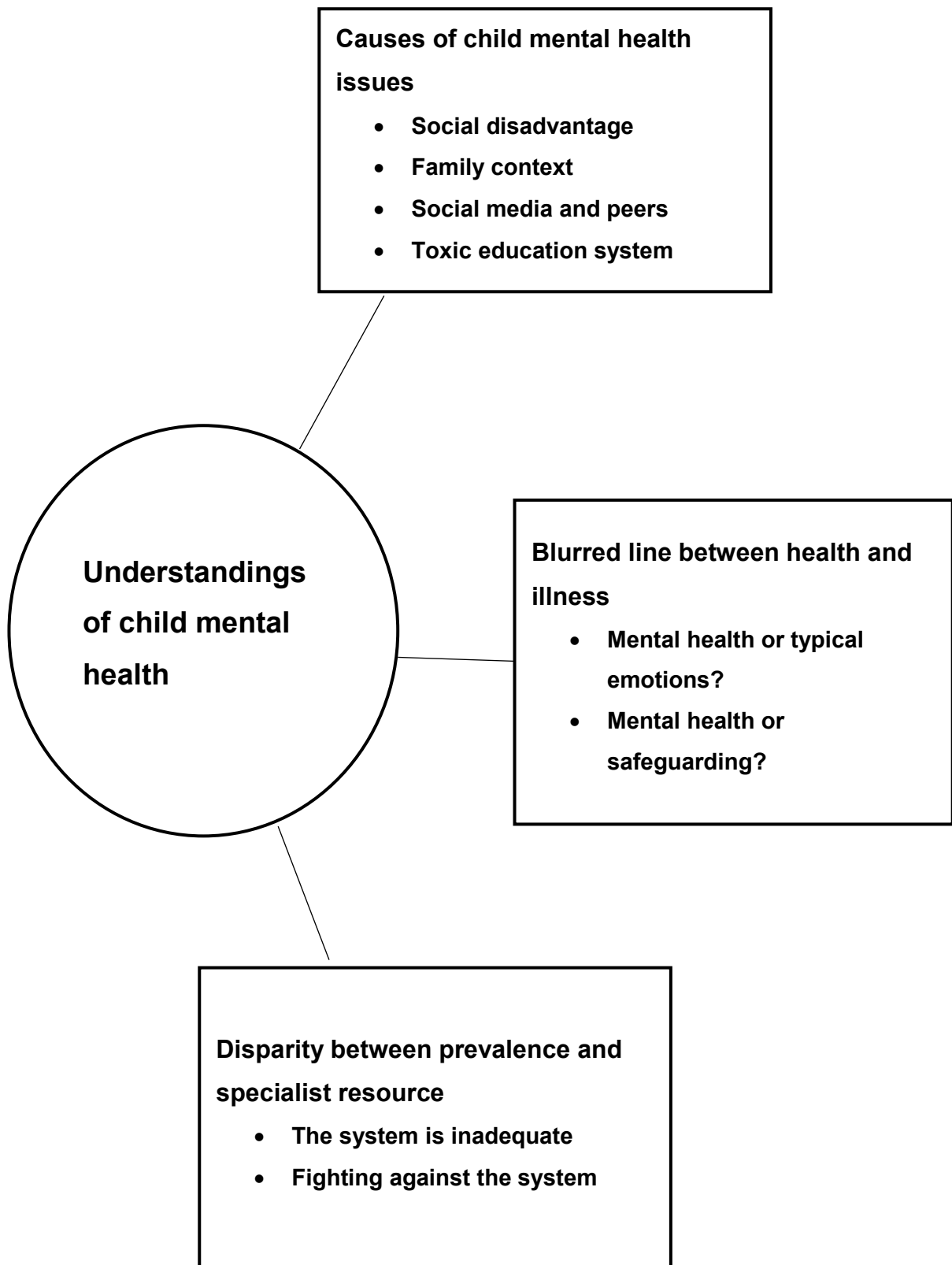
469 little perspective of the school that I teach in it's just I just

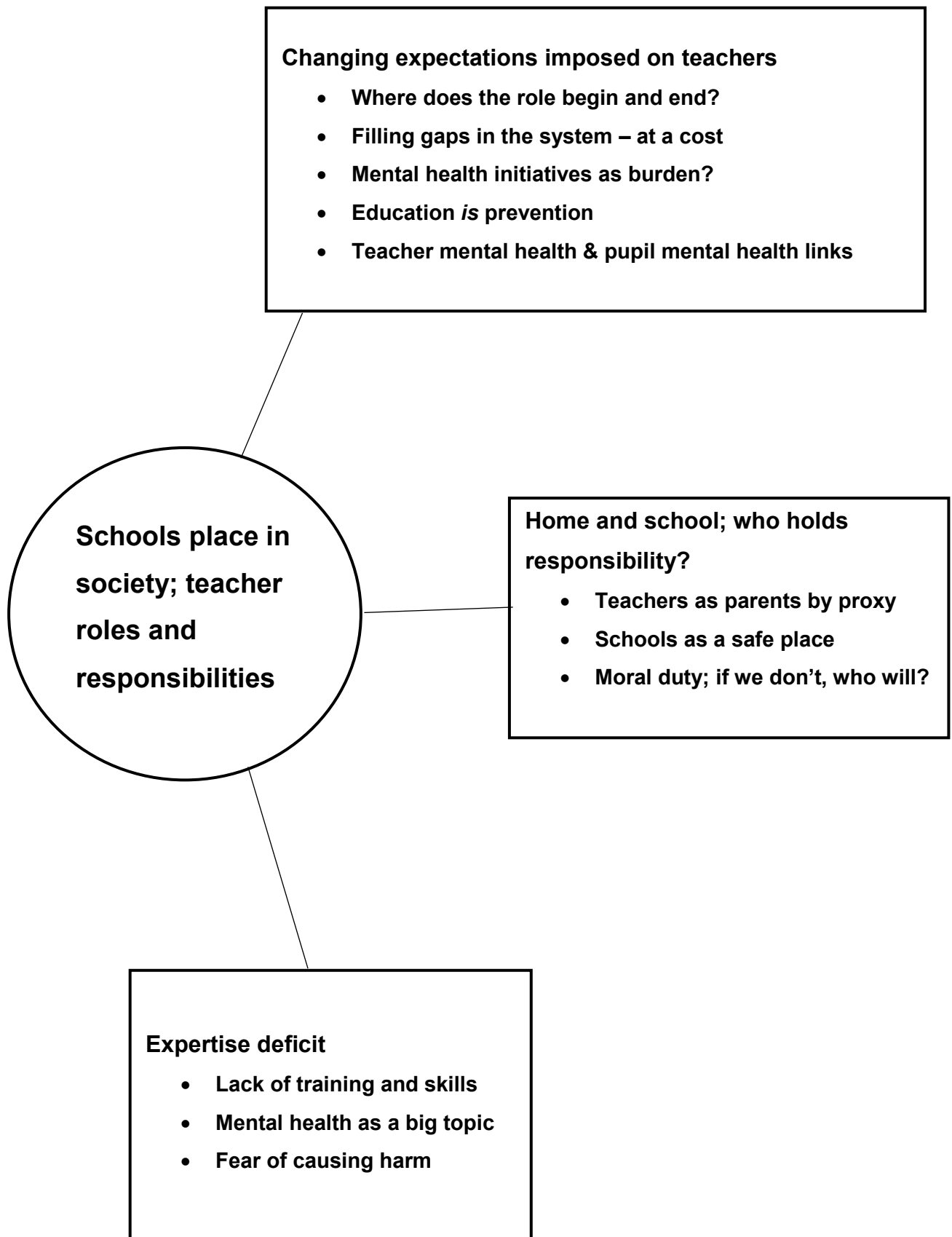
470 find it interesting I just think, is there more... is that sort of a

471 consequence of other things as well that are affecting

472 children's mental health...

Appendix B: Thematic Mapping





Appendix C: UEL ethics Review letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Luis Jimenez

SUPERVISOR: Kenneth Gannon

STUDENT: Amy Edwards

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Primary school teachers' views on their role in child mental health prevention.

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments required (for reviewer):

Question 11: location of face to face interviews should normally not be at the researcher's home, or participant's home. Student had already also indicated there would be options for skype and telephone interviews. There was another unclear line which also needs clarification /amending: "*Lone working protocols will be followed*" (?? Meaning??) ... and the researcher will check in and out with the research supervisor before and after the interviews.

Question 19 - also needs amending, e.g., research data should be saved on a UEL protected PC [rather on student's own laptop].

Invitation letter – needs to use current UEL Invitation letter template, e.g., there are some sections of this template which are missing, e.g., Why have you been asked to participate? What will your participation involve? "Your taking part will be safe and confidential", , What if you want to withdraw?

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*): Amy Edwards

Student number: U0827468@Uel.ac.uk

Date: 03.07.19

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer : Luis Jimenez

Date: 01.07.2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard



Study information Sheet

Primary school teachers' views on their role in child mental health prevention.

Hello,

My name is Amy Edwards and I'm a Trainee Clinical Psychologist, completing a Professional Doctorate in Clinical Psychology at the University of East London. As part of my Doctoral training, I'm carrying out a research study which involves interviews with primary school teachers. Below is some information to help you decide whether you would like to participate in the study.

Why are you being asked to participate?

The research aims to increase understanding of the perspectives of primary school teachers on their role in the prevention of mental health issues in pupils. I am keen to hear your views and experiences as a primary school teacher. It is hoped that the research will be of relevance to educational professionals and other professionals who work with children and staff in educational settings.

What will your participation involve?

Interviews can take place at a time and location that is convenient for you. Interviews will last from 40 to 60 minutes and I will record our conversation on a digital recorder. If it is difficult for us to find a suitable time/location for the interview, we could talk via Skype or telephone. If you would like to take part, please contact me by email at U0827468@uel.ac.uk.

Your taking part will be safe and confidential

After the interviews, I will listen to the recordings and type them up. All interviews will be anonymised. If any identifying information is mentioned (including names, schools or

locations) this will be changed in the transcripts. The transcripts may be read by my University supervisors and examiners.

The information you share with me will remain confidential. The only exception to this is if you were to share information that indicates you or somebody else may be at risk of harm. If this happened, I would need to discuss this with my research supervisor. I would try to let you know if I needed to share information for this reason.

The interview recordings and transcripts will be stored on a password-protected computer for 3 years, so they can be used in any future publications. After 3 years they will be safely destroyed.

What happens if you want to withdraw from the study?

You are free to change your mind at any point, even after the interview, and you don't have to say why. If you decide to leave the study before the interview data is analysed, all the information you provide will be destroyed and will not be included in the research. If you decide to leave the study more than 7 days after your interview, the information you provide will not be destroyed and will be included in the research because it will have already been analysed at this point.

Please feel free to ask me any questions. If you choose to participate, you will be asked to sign a consent form before the interview. Please keep this information sheet for future reference.

Thank you for your time

For any study specific queries please contact Amy Edwards, Email: U0827468@uel.ac.uk

If you have any questions or concerns about how the study is being conducted, please contact the study's main supervisor: Dr Kenneth Gannon, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: 0208 223 6674. Email: k.n.gannon@uel.ac.uk

or: Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: t.lomas@uel.ac.uk)

Participant Consent Form

Primary school teachers' views on their role in child mental health prevention.

Name of Researcher: Amy Edwards

1. I confirm that I have read the information sheet for the above research study and have been given a copy of it to keep. I have had the opportunity to ask questions about the information provided and have these answered by the researcher.
2. I understand what is involved in taking part, that my participation is voluntary and that I am free to withdraw without giving any reason.
3. Should I decide to withdraw within 7 days of the interview, any data that I have provided will not be used in the analysis or subsequent publications. If the decision to withdraw is made after 7 days of the interview, the data will still be used because it will be analysed by this point.
4. I understand that my involvement in this study will remain confidential. Only the researcher will have access to identifiable data. It has been explained to me what will happen once the research study has been completed.
5. I agree to the interviews being audio-recorded by the researcher

6. I fully consent to participate in the above study:

Participant's Name (BLOCK CAPITALS):

Participant's Signature: Date:

Researcher's Name (BLOCK CAPITALS):

Researcher's Signature: Date:

Appendix F: Semi-structured interview schedule

- Can you tell me your thoughts about what contributes to children's mental health problems?
- Can you tell me about your understanding of primary school teachers' roles in the prevention of child mental health problems?
- Has this changed at all during your time teaching?
- What are your thoughts about what is expected of you and your colleagues in this role?
- What are your thoughts about recent government plans to provide all new teachers with training to 'spot the signs' of mental health problems in pupils?
- ...and the plan for teachers to have access to materials for the provision of mental health education for all primary school pupils?
- Is there anything that gets in the way of you being able to play a role in the prevention of child mental health issues? Are there any challenges/obstacles that primary school teachers face?
- Is there anything that helps you to be able to play a role in the prevention of child mental health issues? Are there any opportunities that primary school teachers can make use of?
- Is there any further training, information or support related to child mental health that you think could be beneficial for you in your teaching role?

Appendix G: Participant Debrief Sheet



Participant Debrief Sheet

Thank you for participating in this research study and contributing to a better understanding of teachers' views on their role in the prevention of child mental health issues. I hope that the findings of the research will be used to help professionals and services consider some of the challenges, opportunities and dilemmas teachers encounter in the current educational context.

If you have any questions about the study after today, please feel free to email me on U0827468@uel.ac.uk

Please find below information on where you can access support if you feel you need it following the interview. I have also included a reminder of what will happen to the information you have shared and your right to withdraw from the study.

Support

The **Education Support Partnership** is a UK charity that provides mental health and wellbeing support to all educational professionals.

- They provide a 24/7 free and confidential helpline on: **08000 562 561**
- Website: **www.educationsupportpartnership.org.uk**

A reminder of what will happen to the information you share

- I will listen to the recording of our conversation and type it into a transcript. Any identifiable information will be altered. The transcripts may be seen by my university supervisors and examiners. Quotations that are used in the written report will be selected carefully to minimise identifiability.
- The interview recordings and anonymous transcripts will be safely stored and deleted after 3 years.

Information on withdrawing from the study

If you decide that you would prefer not to participate in the study you are able to withdraw within 7 days of the interview. You do not have to give a reason and the information you have shared will be destroyed.

Thank you very much for your time and participation in this research

Amy Edwards

Trainee Clinical Psychologist